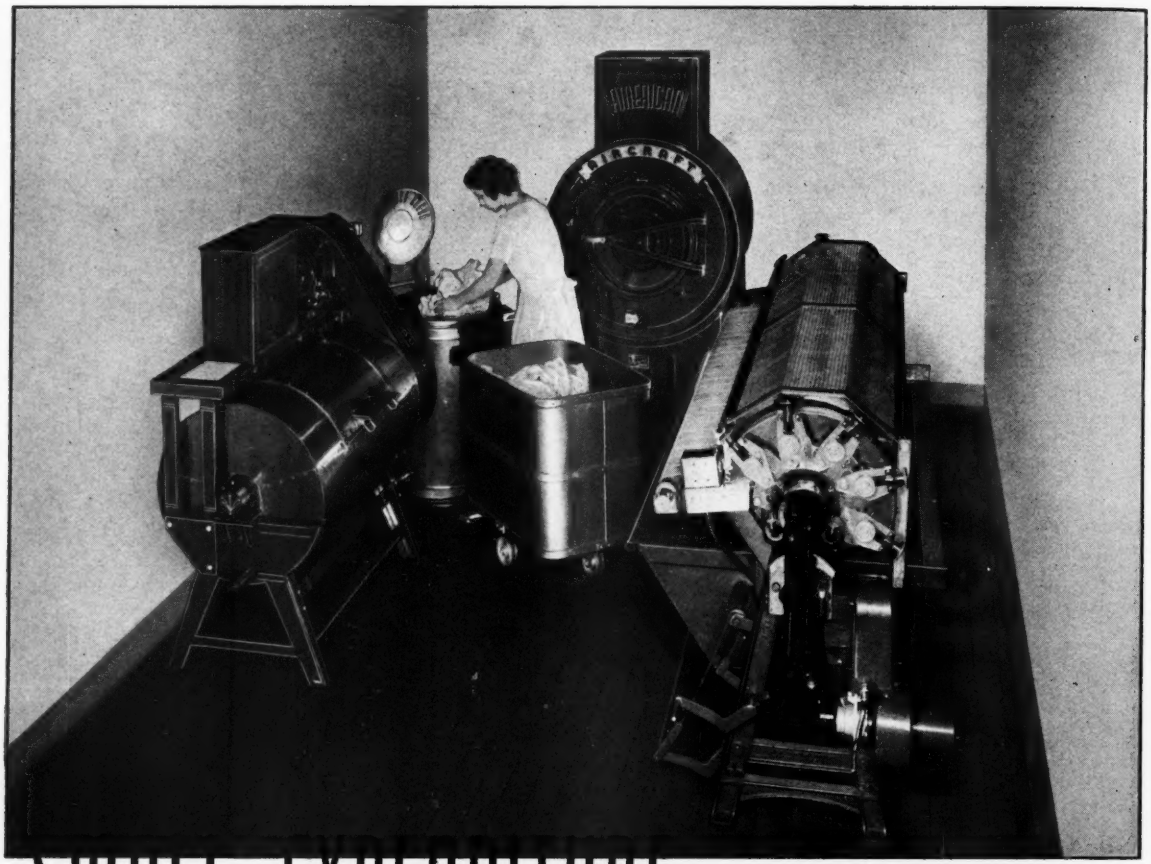
TORONTO, OCTOBER, 1941

THE CANADIAN HOSPITAL

· OFFICIAL JOURNAL · CANADIAN HOSPITAL COUNCIL ·



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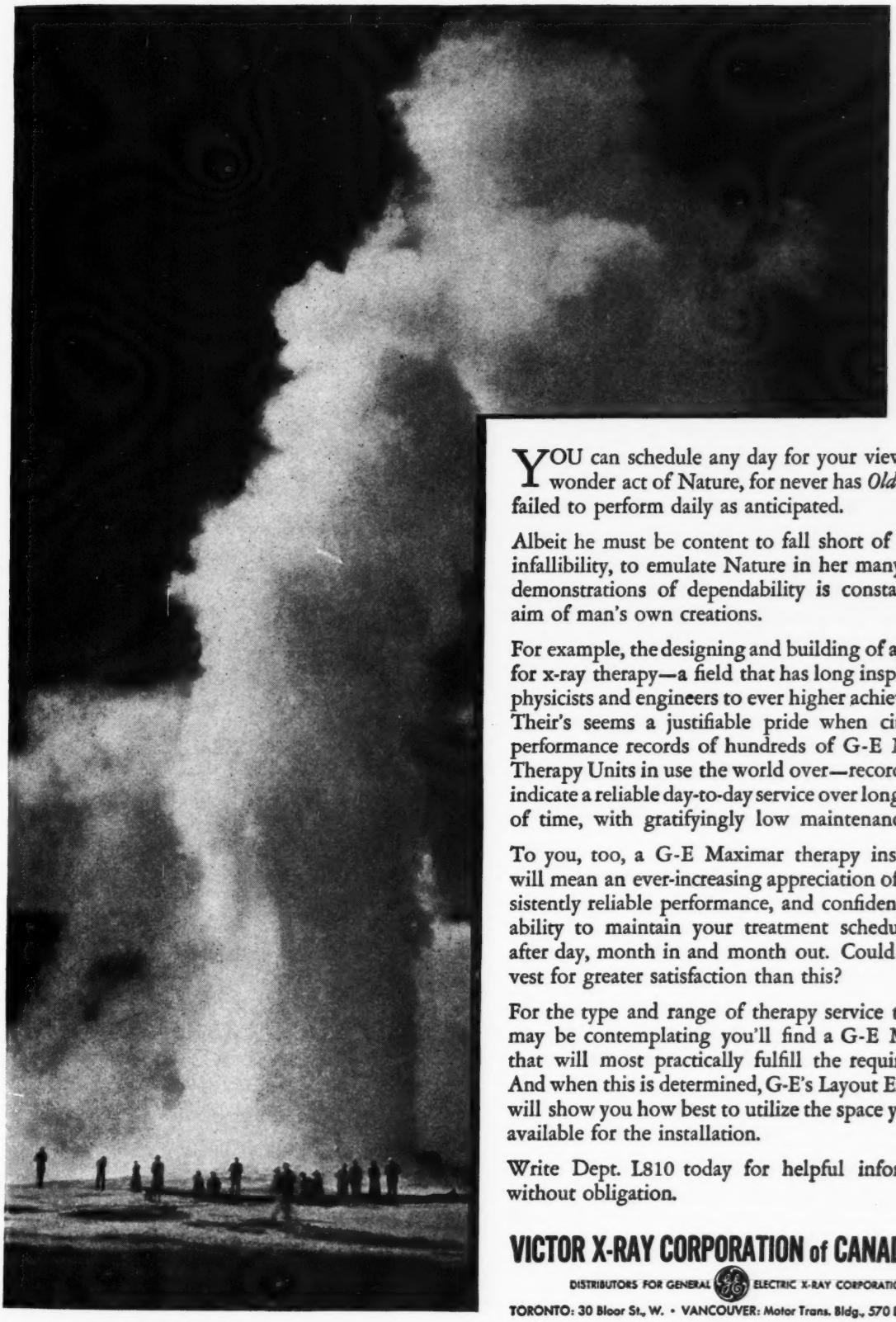

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"The Canadian Hospital"

Official Journal of the

Canadian Hospital Council

Vol. 18 OCTOBER, 1941 No. 10

CONTENTS

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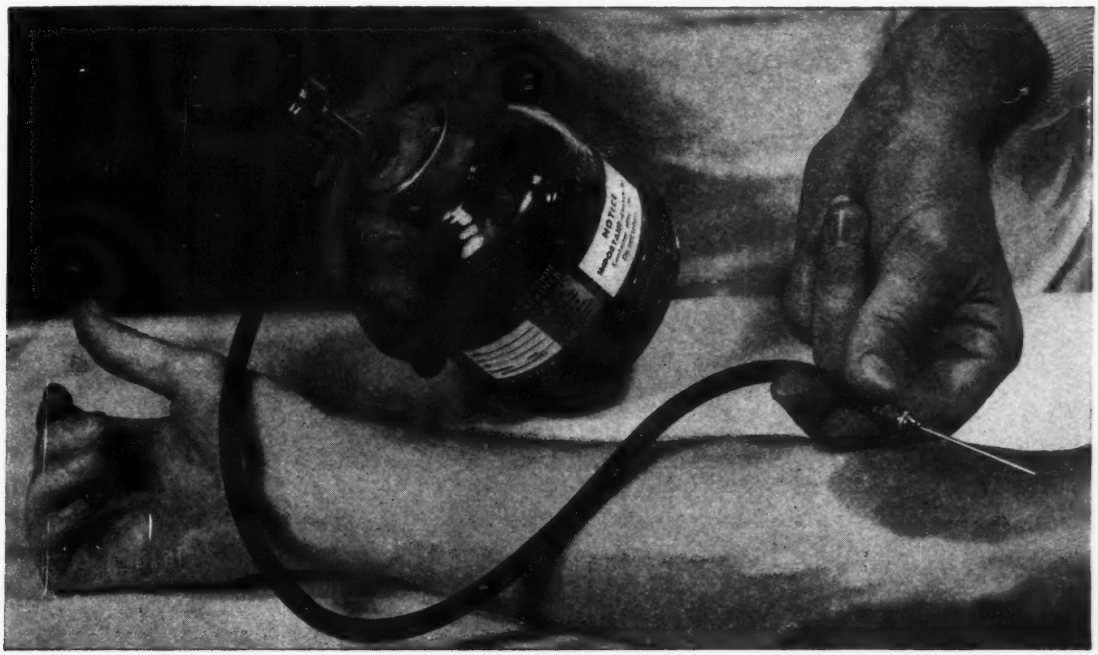

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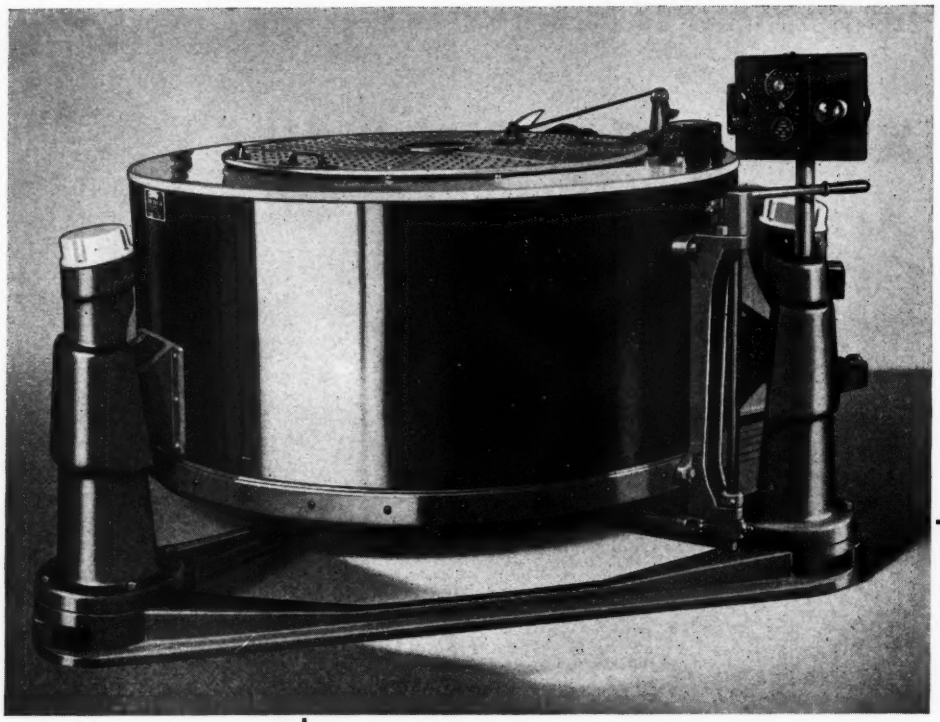

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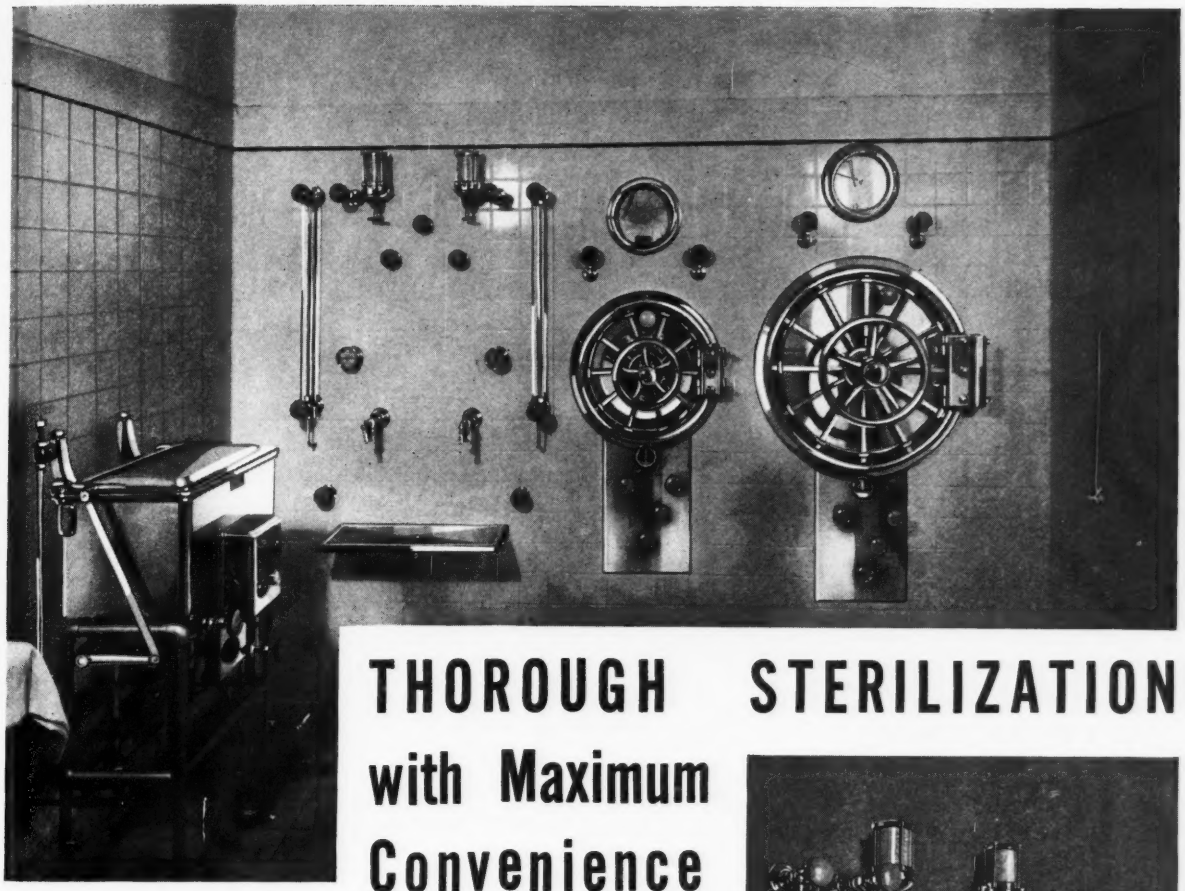

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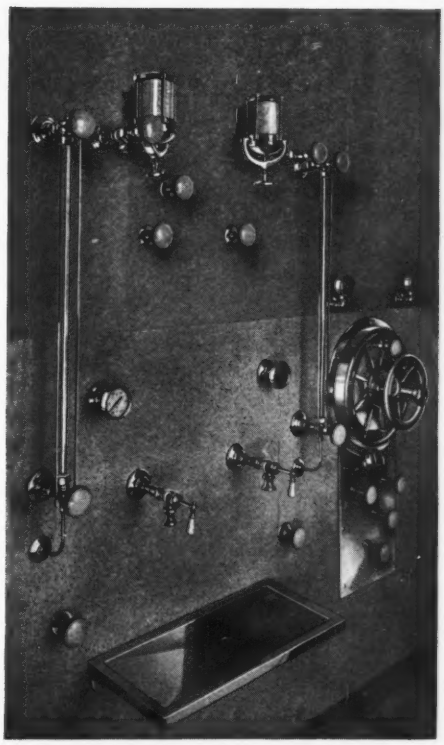

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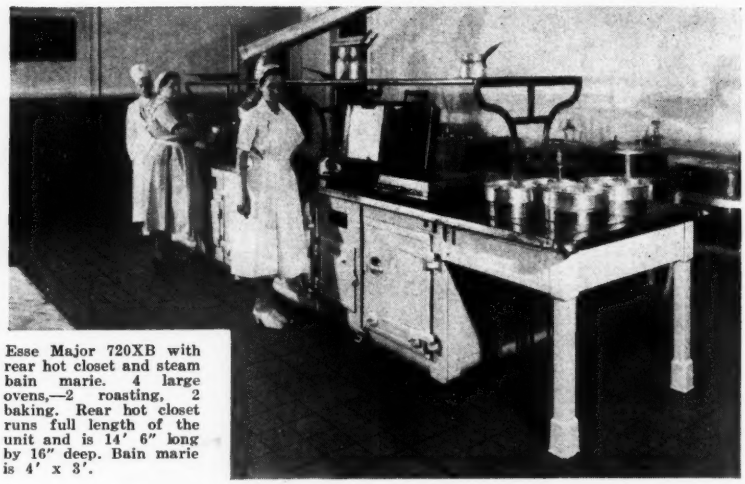

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The CANADIAN HOSPITAL

Toronto, October, 1941 Vol. 18 No. 10

Presidential Address

To the Canadian Hospital Council

GEORGE F. STEPHENS, M.D.

HAVING outraged tradition through a set of fortuitous circumstances by presenting a second presidential address before this organization, may I refer back to what was said at the last biennial meeting in 1939.

The locale of the conference is changed. My own position has changed. The war is two years older, yet the remarks made in 1939, with minor changes only, are as appropriate now as then, in some cases even more so. I am tempted to repeat my address and question if any but a very few of my listeners here or subsequent readers when published would detect this action of self-plagiarism. As a compromise let me quote myself as in 1939 and present some 1941 comments.

(then) "The Council has been found to be an excellent avenue of intercommunication between hospitals and also between the hospitals and governments."

I am glad to say that in my opinion this is even more true in 1941. The Council's effort in promoting Canadian unity is no small part of its achievement.

War Time Co-operation

(1939) "The Council desires to express to the Government of Canada its willingness to support the Federal Government in any way possible in this day of crisis. . . . Principal discussion at its coming meeting is ways and means whereby our hospitals and their personnel can be of most service to the Empire and the cause of freedom."

The acknowledgement of this was an expressed willingness to discuss informally with any committee of the Council what was anticipated, adding, "It is therefore most essential that there be a liaison between representatives of your Association, speaking for all hospitals, and ourselves."

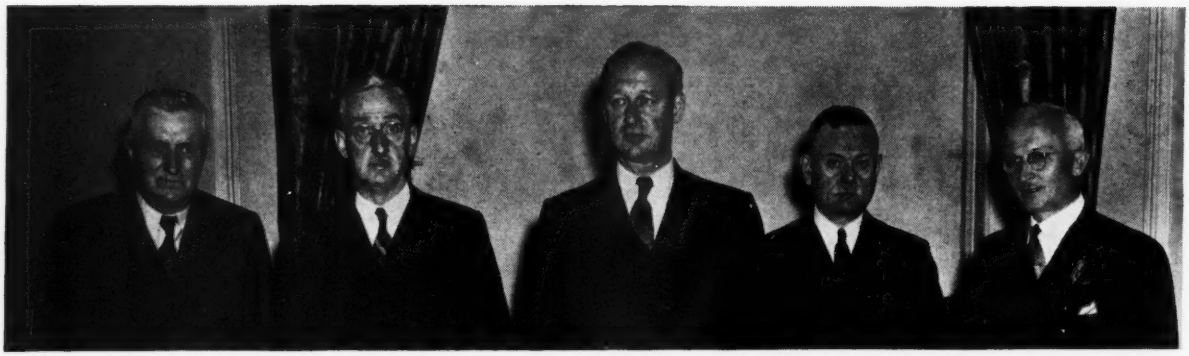
In response to the suggestion for "liaison" I stated:

"We should have direct representation in an advisory capacity with the D.P.&N.H. so that the hospitals may be continuously informed as to needs and plans. We should take care not to be stampeded in regard to the furnishing of war beds unless sure they are required, or in regard to the disruption of our staffs by enlistment where such personnel would be much more valuable in their civil capacity. We feel that properly applied national service will safeguard the position of the public hospitals and also ensure equal if not better care for the Defence Forces in those hospitals which may be called upon to care for them."

A pious wish. Idealistic perhaps, for we had not then got down to the level of practical politics.

The member organizations of the Canadian Hospital Council are the people who have pioneered hospitalization in this country. They are informed. They are accustomed to think in terms of community values, not in terms of selfish considerations. Their advice should be heeded not ignored. It has not been ignored, it has just not been asked. Nevertheless the Council still remains prepared to assist or advise whenever requested.

Aside from this understandable feeling of frustration the relations of



The C.H.C. Executive, 1941-43. Dr. A. F. Anderson, Edmonton; Mr. H. G. Wright. 1st vice-president, Saint John, N.B.; Dr. George F. Stephens, president, Montreal; Mr. J. H. Roy, Montreal; and Dr. Harvey Agnew, Secretary, Toronto. Dr. A. K. Haywood, 2nd vice-president, Vancouver, is not shown.

the Council with the Federal Departments have been amicable. Maintaining these has been and is one of the chief functions of your Executive Committee.

Bed Contracts for the Care of the Defence Forces and Pensioners

The basic contract drawn up before the war for the hospital care of protegés of the D.P.&N.H. has been continued and is meeting with general satisfaction from the hospitals, once they understood that they individually have bargaining powers with the Department and that the contract as offered is an effort to obtain uniformity in the services rendered. Your Council took the position in peace time and reaffirms it now that "all contracts for hospital care must be equitable and based on the full cost to the hospital." Ottawa has accepted this principle. The hospitals in turn must know their own costs and should support the Government in a "no profit" as well as a "no loss" arrangement.

Unemployment Insurance

As you are aware the hospitals secured exemption for their employees and themselves in the payment of unemployment insurance premiums. The argument put forth was that there is no unemployment in hospitals. Therefore, hospitals and hospital employees would be penalized in being required to pay towards a fund from which they could not at any time hope to receive a return benefit. This argument was accept ed. The hospitals are in honour bound to live up to the claims made on their behalf and make sure that there *is no unemployment.* If temporary lay-off of permanent employees is necessary because of interruption of business, these employees should be retained on the pay roll and paid an amount at least equal to what they would draw from the Unemployment Insurance Fund. It would be wise for the hospital from its own resources to set up a reserve fund for these slack periods. They are so few that the hospital will still be somewhat ahead and the employee will not be penalized.

Construction of Hospitals for War Purposes

A letter from your Executive Committee sent to the Prime Minister suggested in part that:

"In communities where competently operated civilian hospitals exist it should be possible to arrange for new construction as a wing or annex to the civilian hospital. . . . At the close of the war should such accommodation not be needed for the care of soldiers it could be turned over to the civilian hospital on a basis to be determined at the time of erection or at the time of the turnover. . . . The suggestion is submitted with the thought that in areas where such a plan is feasible the arrangement would permit the maximum, ultimate use of buildings and equipment and should prove of value in effecting national economy."

A very courteous acknowledgement was received from the Right Honourable Mr. King stating that the representations will be brought to the immediate attention of his colleagues and that fullest consideration will be given to the matter by the War Committee of the Cabinet.

As a result, a meeting was held between representatives of the Canadian Hospital Council and the medical directors of the three Defence Forces and of the D.P.&N.H. The principles enunciated by your representatives were accepted and an agreement reached which was subsequently approved by the Ministers of the departments concerned. The wording of the agreement is as follows:

"The Inter-departmental Hospital Committee, in conjunction with representatives of the Canadian Hospital Council, agree to the general principle of utilizing civilian hospital facilities where conditions warrant, but are of the opinion that each case where additional hospital accommodation is required, should be judged as an entity, taking into due consideration the following factors:—

(1) Primary cost of construction
(2) Subsequent cost of operation
(3) Distance from concentration of troops
(4) Speed of construction
(5) Type of cases the Forces have to treat (venereal and mild infections).

"Any representations with respect to a Federal addition requested by a civilian hospital should be made by the local authorities directly to the Federal authorities."

Your Executive Committee particularly wishes to emphasize that this policy having been accepted can now be quoted and any representations for local consideration in any part of Canada must be made by that locality direct with Ottawa. Your Committee is obviously unable to adjudicate as between hospitals when there may be competition for a Government contract.

Mother Audet of Campbellton, N.B.; Mr. Fraser Armstrong of Kingston; Father V. St. Germain; Dr. L. A. Lessard of Montreal; Dr. J. J. MacRitchie, Halifax; Father Antoine d'Eschambault of St. Boniface and Dr. J. H. Holbrook of Hamilton, Ontario, at the delegates' table.

Hospitalization of Soldiers' Dependants

This presents an increasingly difficult hospital problem in almost every part of Canada, as will be realized from the following figures secured from the Dependants' Allowance Board:—

As at June 30th there were 105,000 accounts for Separation Allowance for wives and children; approximately 16,000 accounts for Dependants, principally parents; a total of 121,000, which is an increase of 12,000 accounts in the past six months.

There were 105,000 accounts for wives and children alone, an increase of 8,000 in the six months.

The accounts in pay for the latter take care of 146,000 children an increase of 30,000 children, but remember that Separation Allowance only covers two children in the family, so that the actual number dependent on Separation Allowance and Assigned Pay for a living is not known.

The Separation Allowance and Assigned Pay are inadequate to provide for more than the basic standard of living and allow no leeway for prolonged illness or surgical operation or for payment of doctors' fees and hospital bills, and there is no Patriotic Fund in this war to make up the difference. In those provinces where municipal liability is provided by legislation, municipalities in a difficult financial position, and even others, are disclaiming liability on the ground that these dependants are on Government allowance and therefore the Government is responsible. A further complication is the migration of many of them, thus losing their residence and failing to qualify for a residence in the new abode.

Had we thought of it earlier we would have suggested that $1.00 a month be deducted from the Separation Allowance to provide a complete medical and hospital service on a pay basis, without the element of charity, for each dependant. Hospitals would give minimum rates and in all probability the medical profession would do the same. Actually many of them are treating soldiers' dependants free. Representations were made to Ottawa to institute some such plan but, though the suggestion has met with consideration, it is felt not to be feasible at present, for various reasons. One is the magnitude of the job, the difficulty in setting up the organization, and, what I suspect is even more important, that this would promptly be interpreted as a cut in the allowance and would be vigorously protested. Strange as it may seem, the people who need protection the most are often the ones who will do the least to obtain it.

The cost-of-living bonus paid to Government employees and Government-partnered industry employees again revives the question of these inadequate allowances and why soldiers' dependants also should not receive the bonus on a cost-of-living basis. If this is not accepted it is hoped that the increases may permit a deduction for medical and hospital services. There should not be great difficulty in having a distribution of funds made by provinces and in obtaining the services of a voluntary board who would make the local distribution. The plan is worth exploring and is commended for your consideration.

National Health Insurance

Sometimes called a "bogey" and sometimes a "godsend". It is doubtful if any government can go to the country following this war without being prepared to submit a broad plan of social legislation embracing almost every phase of social security. In June last a meeting of the Dominion Council of Health was held, at which were present representative physicians and representatives of voluntary health organizations. The object of the meeting was to discuss post-war public health and medical services. Deficiencies in the field of public health and in particular in respect of tuberculosis, child and maternal hygiene, etc., were discussed. The subject of Health Insurance was given consideration, and as a result a study is being made of that subject by the Health Division of the Department of Pensions and National Health, and three model Health Insurance and Public Health Acts are being drawn up. These comprise a model Dominion Enabling Health Insurance and Public Health Act, a model for a Provincial Health Insurance and Public Health Act and a model Dominion Insurance and Public Health Act.

This is purely a Departmental activity and as yet there has been no intimation that it is the intention either of the Dominion or Provincial Governments to consider or implement these Acts.

There is no intimation that the Dominion Government has insti-

tuted this programme or has under consideration the adoption of Health Insurance.

In view of the rumours that have gone across Canada with regard to the Government's proposal, the above paragraphs somewhat clarify the situation.

Physical Rehabilitation

At the end of the last war and subsequently we learned from bitter experience the expense to the country and the waste in man power as a result of lack of appropriate follow-up treatment in post traumatic disabilities. This is a matter of interest to every member of the Council. It is hoped that the importance of this physical rehabilitation is being adequately recognized and that ample facilities will be available as the demand increases.

Economic Situation of Hospitals

The economic situation of hospitals is better since the outbreak of war. Rates, with rare exceptions, have not gone up though commodity prices and wage scales are showing a continual advance. The fact that commodity prices have advanced so slowly and in such an orderly manner is a tribute to the Price Control and Foreign Control Boards, and for this the hospitals are grateful. We have increased occupancy and increased pay occupancy. We have increased commodity prices and higher wages, with the inevitable increase in rates now before us. Economists call this automatic inflation.

Cost-of-Living Bonus

There is confusion over this and its application to hospital employees. In any comparison with industry the following should be borne in mind:

1. *Security of Employment*

In hospitals there is security of employment except for "cause" on the part of the individual or on account of retirement. Because of this hospitals and their employees are excluded from the Unemployment Insurance Act, resulting in a saving to each.

2. *Maintenance in whole or in part*

The main expenses entering into higher cost of living are for shelter, fuel, food, clothing. These are essentials. Employees in receipt of full or even part maintenance are much less affected by advances in the cost of living.

3. *Hospital Care*

All permanent employees, as a rule, have the privilege of hospital care when ill, a perquisite frequently undervalued until needed.

4. *Taxes*

Income Tax, Defence Tax, Sales Tax and the special entertainment or commodity tax are the individual's responsibility and are his or her contribution to carrying on the war or the cost of government.

Remember that the majority of hospitals belong in the voluntary group and differ from Government or Munition Plants. They must earn their own way for all additional expense. They must pay higher prices for building, for fuel and food and clothing (linen, blankets, etc.) and very much more for drugs and surgical supplies and equipment.

Nursing

In addition to army nursing and the renewed openings in the private duty field, there are now opportunities in industry, particularly where munition plants are established. These appointments are at salary scales that the hospitals, with fixed incomes, cannot meet. Not only are they attractive positions, but the holder has a feeling that she is doing her part in the war effort. International border restrictions are being released and graduate nurses may again cross the line without fear of the immigration authorities. On the American side particularly, and this directly reflects on our Canadian hospitals, there is a demand for far more general duty nurses than can be supplied. The situation is so acute that some hospitals are putting on drives to increase the enrollment of their schools, claiming it is a patriotic duty that young women can perform to enter the school now and be ready three years hence when her services may be vitally needed—the long view but a wise one.

Recently a call has come in for three hundred Canadian nurses to go to South Africa. Already one group has embarked and others will leave at stated intervals.

The Journal

Brief reference is made to this in passing, not because it does not merit more extended comment but because a detailed report will later be presented by the Editor.

Our official organ has grown both in quality and stature. It has broadened the range of articles appearing therein, but it cannot hope to be better than its writers. I would, therefore, emphasize the importance of our people contributing articles and news items to the Journal. Notes about hospital activities; photographs of general interest; items outlining a new type of reorganization or new method that has been devised or describing an original piece of equipment. These in addition to longer articles of general interest are appreciated. Remember the Journal has only a part time editor who is carrying out a host of other activities for us.

Study Reports

These are for your consideration. They represent a great deal of work on the part of a few that the many may benefit. They bring before you individual or small group opinions that it is your duty and privilege to criticize and approve or amend. When this is done the reports are published and distributed to the hospitals of Canada at considerable expense. They form an up-to-date, authentic and complete hospital library and are invaluable—if they are read. Are they read? Are they retained? I have much doubt in this respect. Make up your mind and pass on the word to your confreres that when these reports reach your hospital they should be circulated and read. Many of them can with value be made the subject of hospital conferences or an inter-hospital meeting.

Blood Transfusions Therapy

The valuable research work of the members of the staffs in the School of Hygiene and the Department of Physiology at the University of Toronto under the direction of Dr. C. H. Best, an undertaking which has as its objective the preparation of human blood serum for use in the treatment of shock following injury and haemorrhage, is making the hospitals as well as the medical staffs conscious of the importance of having blood supplies available in a suitable form for instant use.

At the Connaught Laboratory a serum in dried form is prepared which is available for use anywhere merely by the addition of distilled water. This serum having been proved to be a valuable agent for

the treatment of war casualties, the Federal Government through the Department of Pensions and National Health requested that the project be extended. It has been agreed that the Government will provide the funds to finance the processing of the blood and the blood serum in the preparation of dried serum, and the Canadian Red Cross Society will obtain the donors, arrange clinics where they can be bled and transport the blood to the Connaught Laboratory. Distribution is the responsibility of the Department of National Defence and the Department of Pensions and National Health. The Federal Government made an appropriation this year of $140,000 to place in operation additional equipment and carry on the services after the completion of the installation. The Red Cross Society provides $25,000 for equipping centres and organizing the blood donor service.

Already provision has been made for sufficient quantities for the Defence Forces both at home and abroad, and arrangements are also made to ship weekly supplies overseas for the use of the needy civilian population. This is a real achievement.

Now that the processing of dried serum has become fully developed, is it not time to make provision for the civilian population in Canada, not merely those injured as a result of direct enemy action, which may well occur, but from other hazards not unassociated with the war, such as sabotage or explosion in munition plants? It is all very well to say that these can be treated by blood transfusions in the ordinary way. So they can within limited numbers, but for anything approaching disaster existing blood banks would very quickly be depleted and time would be occupied in obtaining other bloods; time that could well be spent in the direct care of the patients. Could not some arrangement be made whereby civilian hospitals could draw on these supplies, irrespective of the financial category of the patient? If a pay patient or one coming under "Compensation" then a charge for the blood would be made which could be turned over to the Red Cross to further supplement its efforts in the collection and handling of blood. In this way there should be no criticism of the sale of "donated" blood for money.

Rapport du Président

Congrès du Conseil des Hôpitaux du Canada

GEO.-F. STEPHENS, M.D.

LA présentation de mon second rapport présidentiel n'est pas un défi; toutefois, je dois m'avouer coupable d'avoir en quelque sorte brisé la tradition du Conseil des hôpitaux du Canada, en remplissant l'office de président pendant un second terme.

Me serait-il permis de faire allusion aux décisions prises lors de la dernière assemblée de votre Conseil, en 1939, et d'en faire la comparaison avec les besoins actuels?

Le décor est changé, ma propre situation l'est aussi, la guerre s'est prolongée de deux ans; cependant, les mesures que votre Conseil préconisait en 1939, sont restées à l'ordre du jour à l'assemblée de 1941.

Je serais tenté de répéter tout simplement le discours présidentiel que je prononçais lors du dernier congrès. Comme compromis, qu'on me permette de faire ressortir les points saillants de mon discours de 1939, dans le but d'en faire le rapprochement avec mes remarques de l'année 1941; voici:

1939—extrait du texte.—"Le Conseil des hôpitaux est le médium par excellence de l'échange d'idées entre les hôpitaux et les gouvernements".

Mon opinion d'alors sur l'efficacité de votre Conseil s'est grandement accrue.

1939—extrait du texte.—"Le Conseil désire assurer au Gouvernement canadien sa coopération entière, touchant les mesures d'urgence devant être prises pendant toute la durée de la guerre... Premier débat du congrès: initiatives que doivent prendre les hôpitaux et leur personnel, en vue de mettre leurs ressources au service de l'Empire pour la cause de la liberté".

Nous étions alors consentants et anxieux de discuter amicalement les besoins avec les comités, quels qu'ils soient, et de prendre les décisions qui s'imposaient.

1939—extrait du texte.—"Il est essentiel qu'une liaison soit établie entre les représentants de votre Conseil; ceci étant le désir de tous les hôpitaux du Canada et du Conseil des hôpitaux".

A cette suggestion, je répondais, 1939—extrait du texte: "Il nous serait nécessaire de nous assurer une représentation directe, sous la forme d'un comité aviseur, au Département des Pensions et de la Santé nationale, nous permettant d'être tenus constamment au courant des besoins et des changements qui pourraient surgir.

Il serait injuste de demander aux hôpitaux d'augmenter leur capacité hospitalière, précipitamment et sans raison suffisante. Le personnel compétent des hôpitaux ne devrait pas être appelé à faire du service quelconque dans l'armée, si son entraînement dans le service hospitalier le rend plus utile à l'hôpital qu'à l'armée. Nous croyons que dans l'intérêt national, l'efficacité hospitalière du Canada devrait être maintenue à son plus haut point, afin d'être constamment en mesure de rendre les services requis autant par les populations civiles que par l'armée".

Idéalisme, peut-être, sincère, toutefois. Il faut ajouter que nous n'étions pas alors familiarisés avec les rouages politiques:

Les organisateurs du Conseil des hôpitaux sont les pionniers du système d'hospitalisation au Canada, des hommes renseignés, habitués à penser avant tout aux besoins des populations, ignorant leurs intérêts personnels. Leurs conseils devraient être acceptés.

Vous pouvez être assurés que quoi-

We are indebted to Mr. R. Laporte, Montreal, for these translations.

Photographs by Mrs. Leonard Shaw

Sister Marie du Cœur Immacule, of Quebec City; Father F. V. Germain of Quebec and Mr. R. Laporte of Montreal, in serious conversation.

que l'avis du Conseil des hôpitaux n'ait pas été demandé par nos gouvernants, lors des discussions et règlements des questions hospitalières, le Conseil des hôpitaux demeure néanmoins au service des autorités.

La base fondamentale des contrats intervenus entre les hôpitaux et le Département des Pensions et de la Santé nationale, est apparemment satisfaisante, puisque nous n'avons reçu aucune plainte sérieuse de la part des hôpitaux. L'intervention de votre Conseil a été nécessaire, à plusieurs reprises, cependant; son attitude est restée la même, à savoir, que les contrats devraient être sur la base de "sans profits et sans pertes", les hôpitaux connaissant leur coût de revient et les gouvernements acceptant le principe.

Les hôpitaux ont obtenu du Gouvernement leur exemption à la Loi de l'assurance-chômage. La raison qui a motivé cette exemption est le non-chômage dans les hôpitaux. Les autorités ont réalisé qu'il aurait été injuste envers les employés des hôpitaux, de leur demander de participer à un fonds duquel ils ne pouvaient espérer retirer de bénéfice. Les hôpitaux doivent évidemment remplir leurs obligations, à savoir, s'assurer, qu'en effet, il n'y ait pas de chômage dans les institutions hospitalières. Advenant la nécessité d'un renvoi temporaire d'employés permanents, pour quelque raison que ce soit, cette catégorie d'employés devra être maintenue sur la liste des salaires, et une somme au moins égale à celle qui lui serait payée par l'assurance-chômage devrait lui être versée.

Il y aurait lieu, je crois, que les hôpitaux, afin de faire face à une telle éventualité, établissent une réserve suffisante de fonds à cet effet. Il n'y a aucun doute, étant donné la presque impossibilité d'une telle période d'inactivité dans les hôpitaux, que ces derniers réaliseraient un profit appréciable sur le non paiement des primes de l'assurance-chômage; en plus, ils rendraient un service appréciable à leurs employés.

En ce qui concerne la construction d'hôpitaux pour fins de guerre, le comité exécutif de votre Conseil écrivait à l'honorable premier ministre, et lui faisait la suggestion suivante:

"Dans les municipalités où il existe déjà des hôpitaux civils, il serait possible de construire des additions aux immeubles déjà existants, pour l'hospitalisation des soldats. La guerre terminée, ces additions, n'étant plus utilisables pour des fins militaires, pourraient être affectées au service hospitalier des populations civiles. Les conditions de transfert du Gouvernement aux hôpitaux, pourraient être déterminées, soit, à la date de l'érection, soit, à celle du transfert de l'immeuble. Nous croyons qu'avec de tels arrangements, il résulterait une économie appréciable des fonds publics".

Dans sa réponse, l'honorable premier ministre informait votre comité que sa suggestion serait soumise au comité de guerre, pour considération.

Une séance conjointe des membres de votre comité et des directeurs médicaux des trois services de défense et du Département des Pensions et de la Santé nationale, fut tenue. La suggestion faite par votre comité fut acceptée, séance tenante. Nous donnons ici le texte de l'entente conclue:

"Le Comité hospitalier interprovincial, conjointement avec les représentants du Conseil des hôpitaux du Canada, accepte en principe la suggestion qui lui a été faite, concernant l'utilisation des hôpitaux civils pour les besoins de l'armée, quand la chose sera possible. Il est toutefois d'avis que chaque cas devra être traité en particulier, et ce, pour les raisons suivantes:

a) Coût initial de la construction;
b) Coût d'opération subséquent;
c) Distances des centres militaires;
d) Temps requis pour la construction;
e) Classification des malades.

Toute demande pour additions à des immeubles déjà existants, devra être adressée directement aux autorités fédérales par les autorités locales".

Votre comité désire qu'il soit bien compris que son intervention s'arrête à ce point, et qu'advenant le cas où certaines municipalités voudraient prendre avantage de ce plan de construction, elles devront faire leurs arrangements définitifs avec les autorités gouvernementales, à Ottawa: votre comité est incapable d'intervenir entre le Gouvernement Fédéral pour tout contrat consenti par ce dernier.

Un des problèmes les plus complexes de l'heure actuelle pour les hôpitaux, est l'hospitalisation des familles des soldats. A la date du 30 juin 1941, le Bureau des allocations aux femmes et enfants des soldats comptait 105 000 cas. En plus, les allocations aux autres dépendants, exclusivement des femmes et enfants, étaient de 16 000 comptes, soit, un total de 121 000,—une augmentation de 12 000 sur les six mois précédents. Le nombre des enfants secourus était de 146 000,—une augmentation de 30 000 sur les six mois précédents, et il ne faut pas perdre de vue que les allocations ne couvrent que deux enfants par famille, laissant un nom-

bre très considérable d'enfants non secourus.

Les allocations aux familles des soldats sont à peine suffisantes pour leur permettre le strict nécessaire; comme résultat, les hôpitaux sont contraints de les hospitaliser et de les traiter gratuitement, au besoin.

Peut-être aurions-nous pu suggérer que la somme de $1 par mois soit déduite de l'allocation mensuelle aux familles, dans le but de créer un fonds qui aurait assuré les traitements médicaux aux dépendants des soldats; aucune démarche officielle, toutefois, n'a été faite auprès des autorités, à cet effet.

Une allocation ou boni est actuellement versé aux fonctionnaires du Gouvernement, comme mesure de guerre. Pourquoi les familles des soldats, qui ont à faire face à l'augmentation du coût de la vie, ne bénéficieraient-elles pas d'un boni spécial? Dans le cas où cette suggestion ne serait pas considérée favorablement, il resterait la possibilité de l'augmentation de la solde payable aux soldats. Il serait alors facile de faire une déduction raisonnable, en vue de créer un fonds garantissant les soins médicaux et l'hospitalisation à leurs dépendants.

Assurance Nationale

Puisque ce sujet de discussion est sur l'ordre du jour, nous en dirons quelques mots. Ce projet est parfois accepté comme un bienfait, mais plus souvent, il est rejeté comme une malédiction. Nous croyons, étant donné que cette assurance est une mesure d'après-guerre, que cette question sera solutionnée en temps et lieu par nos législateurs. Le projet a été discuté lors d'une assemblée du Conseil de la Santé nationale, tenue en juin 1941. Le but de cette assemblée était l'étude des besoins médicaux de la période d'après-guerre. Plusieurs sujets touchant la Santé nationale ont été passés en revue par l'assemblée, mais aucune décision pratique n'a été prise. Nous ne croyons pas que pour le moment, le Gouvernement ait l'intention d'instituer un tel plan d'assurance.

Un sujet de très grande importance est la réhabilitation des membres de l'armée active, hommes et femmes. Il est grandement temps de donner à ce problème toute l'attention à laquelle il a droit. Sommes-nous plus avancés sur ce point que nous l'étions à la fin de la première guerre? Certains prétendent que non; cependant, la triste expérience que nous avons eue alors aurait dû nous servir de leçon.

Rev. Georges Verreault, past-president of the Council, and Dr. William Delaney, superintendent of the Jeffery Hale's Hospital, Quebec City, face the camera together.

La position financière des hôpitaux s'est sans aucun doute améliorée depuis la déclaration de la guerre. Le tarif hospitalier, sauf dans de rares exceptions, n'a pas augmenté, quoique le coût des comestibles, des produits pharmaceutiques et de tout le matériel nécessaire à l'administration des hôpitaux, y compris les salaires, a augmenté graduellement; heureusement, toutefois, l'augmentation générale a été lente et coordonnée, grâce au comité du contrôle des prix.

L'allocation de guerre ou boni ne semble pas, à notre avis, devoir être versé aux employés des hôpitaux, pour les raisons suivantes:

a) L'employé d'hôpital n'a pas la crainte de perdre son emploi, s'il fait son devoir; ce point a été reconnu par le Gouvernement Fédéral et a motivé son exemption à la Loi de l'assurance-chômage;
b) L'augmentation du coût de la vie ne l'affecte que peu ou pas du tout, puisque, dans la plupart des cas, il est logé et nourri à l'hôpital;
c) Il n'est pas appelé à payer pour les soins médicaux qu'il reçoit.

Impôts et Taxes

Nous réalisons que les impôts et les taxes sont la contribution de l'individu à l'effort de guerre et au maintien des gouvernements. Il n'y a pas lieu, à notre avis, de commenter sur ce point. Nous croyons, cependant, qu'il serait bon de nous rappeler que les hôpitaux ne devraient pas être comparés aux organisations industrielles, et traités sur un pied d'égalité avec ces dernières, dans la distribution des taxes.

Hospitalières

Les hôpitaux se voient forcés de faire face à une grave situation, créée par le rareté des gardes-malades diplômées dans leurs services hospitaliers. Cet état de chose est dû à plusieurs facteurs, entre autres, l'entrée libre des infirmières canadiennes aux Etats-Unis et aux Bermudes, l'enrôlement volontaire dans les services actifs, l'embauchement des infirmières dans l'industrie de guerre, etc. Les élèves dans les écoles se font de plus en plus rares, et ce, à un tel point que certains hôpitaux ont entrepris une campagne de recrutement intense.

Journal—"Canadian Hospital Journal"

Nous désirons rappeler brièvement à cette assemblée que nous ne ferons que peu de commentaires sur le Journal, organe du Conseil des hôpitaux du Canada: un rapport complet vous sera présenté dans quelques instants par l'éditeur lui-même.

Il y a lieu, toutefois, de vous informer que le Journal, depuis la dernière assemblée de votre Conseil, a fait des progrès considérables, autant au point de vue éditorial qu'au point de vue circulation. Nous devons réaliser, cependant, qu'un journal

(*Continued on page* 33)

Report of the Secretary

To the Canadian Hospital Council

TEN years ago, when a small group of enthusiastic hospital administrators and trustees gathered together to set up a Canadian Hospital Council, the future of this organization was not clearly charted. It was agreed that the geographic distribution of our hospitals and the proximity of our southern neighbour made the formation of the usual type of national association with general conventions a dubious venture. It was also agreed, however, that the increasing number of hospital problems of coast-to-coast concern and the importance of setting up national policies made it most desirable that there be set up without delay a national council at least, which could co-ordinate our provincial activities, help us to formulate national policies in our great work, assist the individual hospitals, be our intermediary in federal relationships and, in general, be the parliament of the hospitals.

During this decade, a trying one in the experience of our hospitals, the Council has well justified its existence and it has become a most essential part of our hospital system. Its place is assured.

The past two years have been war years with their many added difficulties and strains. Personnel problems, particularly with respect to nurses, orderlies, interns and other groups, have been trying. Purchasing problems have been emphasized. Less often discussed but of tremendous present and future effect has been the deflection of a vast amount of voluntary effort and support to the various war activities and charities. Although an intangible asset, its loss to our hospitals cannot but be tremendous.

The Defence Programme and Hospitals

Hospitals have been vitally concerned with the Defence Programme. Although the danger of invasion seems remote, extensive preparation has seemed advisable. Hospitals in the Maritimes have participated in local and provincial precautions. Much has been done to prepare for the receipt of civilian casualties, to co-operate in fire prevention and other A.R.P. activities, such as arranging for blackouts, emergency lighting and water supplies, etc. Key people have made every effort to become better acquainted with their potential duties and, at the Pictou meeting this summer, a most helpful demonstration of gas as used in warfare was given. Some time ago a survey was made by the Canadian Hospital Council of the facilities available in civilian hospitals of 50 beds or over. It was found that the question is, Are we doing enough? It is our information that, outside of the Maritimes, very little preparation for actual warfare has been made by hospitals. In most places apparently no precautions have been taken, not even to laying in extra bedding and sutures. Are the hospitals waiting for the local general committees to take the lead? Regardless of the local activity or inertia, all hospitals, even those in the middle west, should take the initiative and be themselves prepared, come what may.

Every hospital, in co-operation with its staff and the local medical society and with the local nurses' organization should know definitely how these three component bodies could co-ordinate their efforts on sudden emergent demand.

It should be added that the Federal Government has been quietly doing a great deal to prepare for hospital needs under such conditions.

Other aspects of our war relationships such as the setting up of training courses for V.A.D.'s and the possible revamping of our intern schedules will be discussed under appropriate headings during this meeting.

At the March Executive meeting it was agreed that the Council should encourage hospitals to give any assistance necessary for the hospital training of technicians, physiotherapists, medical anaesthetists and others needed for war work.

The Provincial Associations

Our provincial associations and sisters' conferences would all seem to be flourishing. The meetings of these associations during the two year period since the last meeting of this Council have been excellent and speak well for the officers in charge. In the west the meetings are now held in sequence thus permitting speakers such as our President to attend the series. In the east the New Brunswick Hospital Association and that of Nova Scotia and Prince Edward Island have now met twice in joint session, an arrangement which has permitted a much stronger and more diversified programme to be presented. The joint programme will be continued next year at Monc-

Mr. James Brady of the Dominion Bureau of Statistics, Dr. Lorne Gilday, secretary of the Montreal Hospital Council, and Miss Ruth Wilson of Moncton, found hospital finance a topic of common interest.

ton. In Ontario, the provincial association, now chartered, has gone into "big business", having this year sponsored and financed the new Plan for Hospital Care which is already growing at a very satisfactory rate.

Legislation and Regulations

The President has already spoken of the new contracts for the care of ex-service men, of the conference on construction of defence hospitals and on the conference respecting health insurance legislation. For these opportunities to discuss these subjects with Ottawa we express our appreciation.

There has been little special hospital legislation passed except the all-embracing War Exchange Tax with its 10 per cent impost on all imports and the War Exchange Conservation Act which has made it difficult to obtain many articles normally used in hospitals. At the Council request, certain additions to the free list have been made, such as identification beads for the newborn; broader interpretations and arrangements have been made, e.g., the use of alcohol for medicinal purposes and permission for the importation of lead impregnated gloves for x-ray work. There is still exemption for the hospitals from the 8 per cent sales tax except in the case of anaesthetics and drugs where an advance of more than 10 per cent on drug costs is made. Announcement has been made of the new regulations preventing radio interference by electrotherapeutic equipment. These regulations become operative January 1st, 1942.

Provincially, a number of important acts have been passed; these will be considered under that item on the agenda.

Constitution and Bylaws

No matters requiring the consideration of the Committee on Constitution and Bylaws have been received. Apparently our present setup meets with general satisfaction, although there is always the thought that some day we may feel the time opportune to broaden into a national association with membership among the individual hospitals.

Hospital Care Plans

There are now approximately 70 of these plans in Canada. Many of

Mr. H. G. Wright, 1st vice-president of the Council and Mr. J. H. Reid, Chairman of the Board of Trustees at Moncton Hospital meet at Montreal.

Mr. J. H. Roy, Montreal and Dr. J. E. de Belle, Montreal, member of the Editorial Board of The Canadian Hospital.

Dr. Harvey Agnew, Toronto, Dr. A. K. Haywood of Vancouver and Mr. Milton George of Deloraine, Manitoba, relax after the meeting.

Miss Margaret Murdock of Saint John, Miss Jean Wilson, of Montreal and Mr. Fraser Armstrong of Kingston.

course are small one-hospital plans and, in many cases, are not very elaborately organized. The largest plan, the Manitoba Hospital Service Association, is growing very satisfactorily. The city-wide plan in Edmonton is making steady progress as is also the plan at Moncton. In Saskatchewan the plans in Regina and in Saskatoon are closely interlocked, a commendable feature. The Plan for Hospital Care in Ontario, sponsored by the Ontario Hospital Association, has become firmly established in Toronto and is now extending throughout the province. In Nova Scotia active steps are now being taken to establish a plan on a province-wide basis. Montreal is now about to launch a city-wide plan and has borrowed a director for the organization period from Winnipeg.

International Accord

The roaming at large of the Hun with his gun and the Fascist with his dagger has tended to bring the peace loving nations closer together. Two years ago in Toronto at the American Hospital Association convention, plans were laid for the creation of a Pan-American gathering. Much has been done since. Last year an institute for administrators was held in Puerto Rica with a large attendance from the three Americas. Many Central and South Americans now attend the Chicago and other Institutes. We are meeting more Mexicans than ever before. All this is as it should be.

A number of our leaders, too, on both sides of the Atlantic are working towards a British-American rapprochement. When the Atlantic is again cleared of its Nazi sharks, it should be possible to arrange for reasonably large groups of programme speakers and delegates to go east one year and another group to journey west two years later. Ultimately the ill-fated International Association may again be revived. A conference will be attended in Atlantic City next week when representatives of the United States, Great Britain, Canada, Mexico and the Central and South American countries will lay plans for setting up an Anglo-American Association.

The 1941 Meeting

This meeting, held in the great hospital centre of Montreal, will depart somewhat from previous custom. Except for the Presidential Address and certain reports, the whole programme will be of a round table nature. Key subjects with leads for discussion appear in the agenda and it is hoped thereby to stimulate discussions in which all of the delegates will actively participate.

Naturally considerable prominence is being given to the effect of war upon our hospital activities and such related topics as federal contracts and the construction of defence hospitals. The nursing committee will report a number of studies, including the controversial one of the extent to which graduate nurses might undertake certain clinical procedures, and the question of hospital training for V.A.D.'s.

Other topics of interest will be the basis of municipal and provincial payments for indigents, workmen's compensation board arrangements, hospital accounting, construction, the choice of nomenclature, the effect of health insurance upon hospitals and a number of other vital topics.

Following the meeting the various study committee reports will be published as bulletins of the Council. As several of the reports could not be completed as early as desired, it was not possible for the printers to get these reports back to us in time for advance distribution. To expect the delegates to approve reports which they have not read is not justifiable. Accordingly the executive committe to-day recommended to the Council that the final approval of these bulletins for publication rest with the incoming Executive Committee to whom any suggestions for revisions could be sent by the delegates.

The Pool

As in previous years, the Executive Committee has agreed that the Pool for travelling expenses of delegates should be again utilized. This has been a strong incentive to distant associations to send delegates and has been instrumental in maintaining the truly national nature of this Council. This action will be placed before you for ratification.

Appreciation

The Council is greatly indebted to the members of the Executive Committee for their continued leadership and service. The members have given unstintingly of their time and thought whenever called upon. Last March a special meeting was held to consider urgent problems then on hand. Our President has been most painstaking in his discharge of his duties and has given his task much thought as his Presidential address has shown. Last Autumn he attended all four western provincial meetings, to the great benefit of all who attended, in February he attended the Midwinter Conference in Chicago and this summer participated in the joint meeting at Pictou. The Council is deeply indebted, too, to the Chairmen of the various study committees and to the members thereof, all of whom have gone to considerable pains to prepare outstanding reports on current hospital topics.

Harvey Agnew,
Secretary.

Rapport du Secrétaire

Congrès du Conseil des Hôpitaux du Canada

IL y a dix ans, un petit groupe d'administrateurs d'hôpitaux, réalisant depuis longtemps que les problèmes des hôpitaux étaient devenus d'une importance nationale, se réunissaient, en vue de jeter les bases d'une organisation qui devait devenir, plus tard, le "Conseil des hôpitaux du Canada" (Canadian Hospital Council).

Le but de cette nouvelle organisation était de promouvoir les intérêts des hôpitaux du Canada en général, d'aider à la création d'associations similaires dans les différentes provinces, et de résoudre les problèmes des hôpitaux; en d'autres termes, devenir la conseillère des hôpitaux dans tout le Dominion du Canada.

Nous avons constaté que dans ces dix années, le Conseil a plus que justifié son existence: il est devenu une partie intégrale du système national d'hospitalisation; sa survivance est donc assurée.

Les difficultés nombreuses auxquelles les hôpitaux ont dû faire face se sont accentuées depuis les deux années de guerre, et plus que jamais, les activités de votre Conseil ont été complexes. Pour ne citer que quelques-uns des problèmes qu'il a dû résoudre au cours des deux dernières années, nous mentionnons: personnel hospitalier, service des achats, participation des hôpitaux et des groupes hospitaliers aux œuvres de guerre, etc.

En ce qui a trait aux problèmes de la défense nationale en temps de guerre, quoique le danger d'une invasion ne semble pas évident, certaines précautions ont dû être prises par les hôpitaux, advenant une conflagration. La partie civile de notre population devra nécessairement être traitée dans nos hôpitaux, qui devront être en mesure de faire face à toute éventualité. Des services de prévention contre les incendies et les raids aériens doivent être organisés, et l'installation de systèmes d'illumination individuels des hôpitaux doit être prévue. L'achat de matériel à pansements et de médicaments en quantité suffisante devra être fait par les hôpitaux.

Lors d'une assemblée tenue à Pictou, au cours de l'été, plusieurs démonstrations très intéressantes ont été données sur les gaz asphyxiants en temps de guerre. Il y a quelques mois, un relevé des précautions prises par les hôpitaux de cinquante lits et plus a été fait; malheureusement, il a été constaté que sauf quelques exceptions, seuls les hôpitaux des Provinces Maritimes ont fait des préparatifs d'urgence.

Chaque hôpital, individuellement, devrait organiser et entraîner son personnel, en vue de pouvoir rendre à la population les services nécessaires en cas de raids aériens, de conflagration ou de paniques en temps de guerre. Il devrait organiser et travailler en coopération avec les autres organisations locales, à savoir, le département du feu, le service de la police et les autres corps publics.

Nous devons faire l'éloge du Gouvernement Fédéral pour le travail considérable qu'il a fait depuis plusieurs mois, en vue de s'assurer un nombre adéquat de lits d'hôpitaux, advenant des raids aériens ou autres calamités.

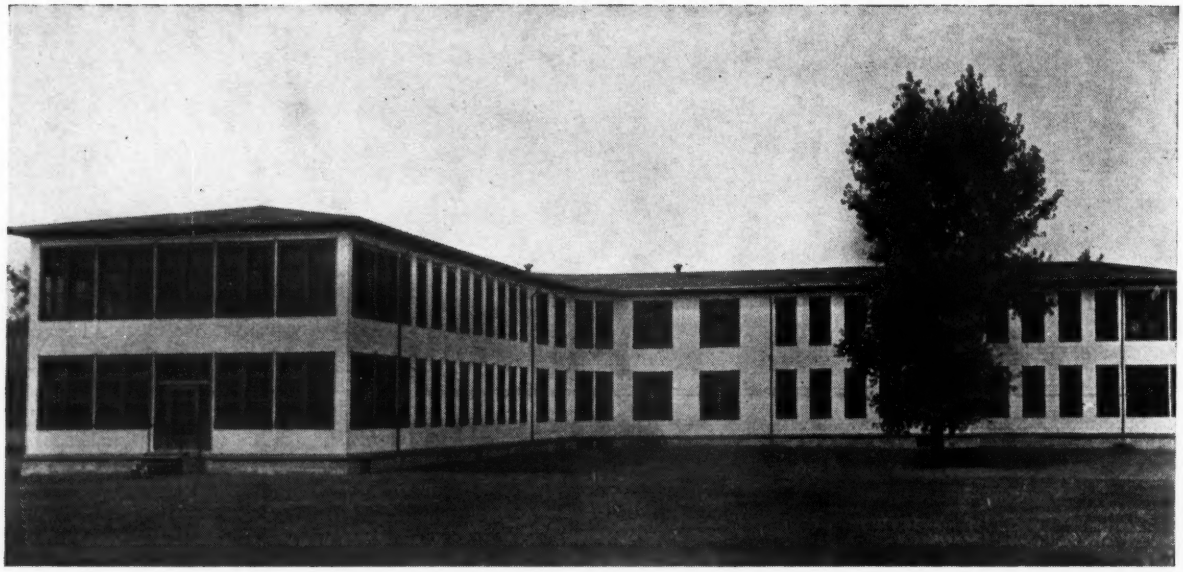
Plusieurs questions d'urgence seront étudiées au cours du présent congrès, et nous espérons que celle de l'entraînement des hospitalières et de la rotation des médecins-internes dans les hôpitaux, sera résolue dans le meilleur intérêt des populations du Canada.

Lors de son assemblée tenue en mars dernier, le comité exécutif de votre Conseil s'est déclaré en faveur d'un plan d'entraînement spécial, visant les techniciens, les radiologistes, les anesthésistes, et autres spécialités nécessaires à un service préventif national, mesure de guerre.

Nous constatons avec satisfaction que les associations provinciales d'hospitalisation semblent être toutes en bonne position financière, et que le travail qu'elles ont exécuté et qu'elles exécutent actuellement, est dans le meilleur intérêt des hôpitaux de leurs provinces respectives, et pour le bien de la population en général.

Dans les Provinces de l'Ouest, de même que dans les Provinces Maritimes, plusieurs assemblées ont été tenues, auxquelles assistait le président de votre Conseil. Le système d'assemblée conjointe, inauguré par les Provinces Maritimes, se continuera encore cette année, la prochaine devant avoir lieu à Moncton. Le programme de l'Association provinciale de l'Ontario est très chargé et très élaboré.

Sister St. Florida, Quebec; Sister St. Gertrude de Nivelles, also of Quebec, and Mother Audet of Campbellton, N.B.



VICTORY PAVILION AT ST. ANNE DE BELLEVUE OPENED

The Honourable Ian MacKenzie, Minister of Pensions and National Health opened the new Victory Pavilion of the St. Anne de Bellevue Military Hospital in September. This new wing which contains over 400 beds brings the total accommodation of the hospital to 1,000 beds.

Le président de votre Conseil vous a donné certaines informations touchant les nouveaux contrats intervenus entre le Gouvernement Fédéral et les hôpitaux, et ayant trait à l'hospitalisation et aux traitements médicaux aux militaires licenciés. Il a aussi parlé des vues de la conférence sur la construction possible d'hôpitaux militaires, d'un plan d'assurance gouvernemental, et de nombre d'autres sujets traités par nos législateurs. Nous apprécions à leur juste valeur les informations qu'il a bien voulu nous donner, et qui rendront possible l'intervention des hôpitaux auprès de la Législature, en temps opportun.

A l'exception de la taxe de dix pour cent affectant l'importation de toute marchandise étrangère au Canada, et qui n'est pas sans causer de très graves ennuis aux hôpitaux, aucune loi touchant directement les hôpitaux n'a été passée par la Législature, au cours de l'année.

A la demande de votre Conseil, certaines additions ont été faites par le Gouvernement, concernant l'importation d'un certain nombre d'articles de première nécessité pour les hôpitaux; entre autres, les perles nécessaires à la fabrication des colliers servant à identifier les nouveau-nés. Une interprétation plus générale a été donnée à certains articles et matériel d'un usage courant dans les hôpitaux, tels que: alcool pour la préparation des produits pharmaceutiques, gants plombés pour l'usage des radiologistes, etc.

Les hôpitaux jouissent, comme par le passé, de l'exemption de la taxe fédérale de huit pour cent sur les achats, sauf pour les médicaments sur lesquels ils réalisent un profit de plus de dix pour cent.

Certaines précautions ont été prises par le Gouvernement Fédéral, en vue de réduire l'interférence provenant des agents physiques en usage dans les hôpitaux et ailleurs; des règlements ont été préparés, à cet effet, et entreront en vigueur le premier janvier mil neuf cent quarante-deux.

Les lois affectant les hôpitaux, passées par nos législatures dans les différentes provinces, seront étudiées par cette assemblée, ayant été portées à l'ordre du jour.

Aucune modification ne semble s'imposer dans la constitution ou la réglementation de votre Conseil. Nous espérons toujours, toutefois, que son champ d'action pourra un jour s'accroître au point de devenir une association nationale groupant les représentants de tous les hôpitaux du Dominion.

Les associations hospitalières semblent être devenues indispensables: nous en comptons actuellement soixante-dix environ; quelques-unes, cependant, n'affectent qu'un seul hôpital. Un des plans les plus importants est la "Manitoba Hospital Association"; viennent ensuite l'association hospitalière de la ville d'Edmonton, et celle de Moncton. Les groupes hospitaliers des villes de Régina et de Saskatoon, en Saskatchewan, fonctionnent conjointement; nous recommandons hautement ce système.

En Ontario, le service hospitalier, qui a été organisé par les associations des hôpitaux de la province d'Ontario, fonctionne d'une façon très satisfaisante; depuis sa création, ce service hospitalier s'est étendu par toute la province. Dans la province de la Nouvelle-Ecosse, une association provinciale est à se former actuellement. A Montréal, la "Quebec Hospital Service Association" vient de s'organiser; les services d'un directeur de l'association hospitalière de Winnipeg ont été retenus à titre d'organisateur temporaire.

Dû à des circonstances incontrôlables, le congrès de l' "International Hospital Association", qui devait se tenir à Toronto il y a deux ans, n'a pas eu lieu; toutefois, l' "American Hospital Association", lors de cette même convention, a demandé la

(*Continued on page* 78)

"Canada Expects"

A Message for Thanksgiving, 1941

WHEN Nelson gave his famous signal at Trafalgar, "England Expects" the scene was changed for everybody present. Instead of the battle fleets soon to be smashed and pounded together and filled with the mangled and torn bodies of wounded and dead men, there was a vision of England. England with wife and home, mother and sweetheart and dear ones. The England of the poet "a little gem set in the midst of the silver sea". An England which embraced everything for which men lived and for which they were not ashamed to die.

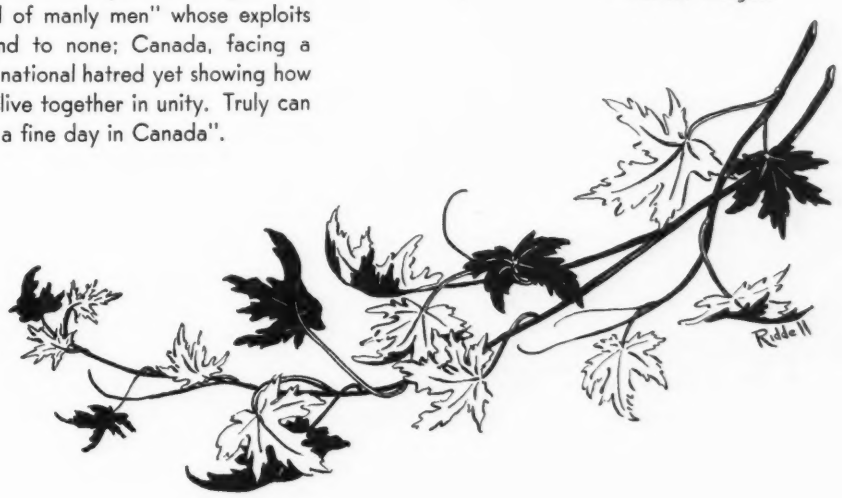
On our 1941 Canadian Thanksgiving—with the Empire ravished by war; with so many hearts anxious and lonely because of sons and daughters, fathers and brothers, husbands and sweethearts facing death on land or sea or in the air in the "far-flung battle lines" all over the world; and with the hallowed memory of those who already have made the supreme sacrifice, fresh and green in our hearts —the signal goes forth "Canada expects everyone to give thanks."

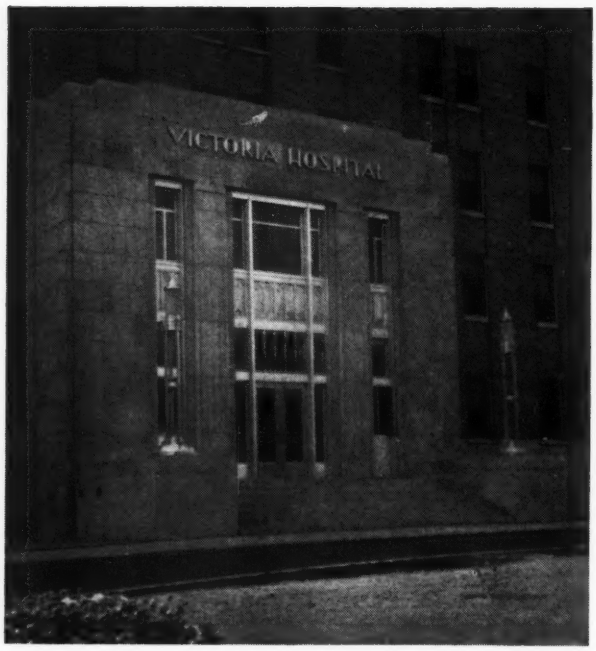
As at Trafalgar the scene changes in our minds and a vision of beauty is presented: Canada, the land of bountiful crops, of boundless forests and of untold mineral wealth waiting to be dug out of the earth; Canada, whose shores are washed by seas teeming with still greater wealth and in whose harbours our ships, and all friendly ones, take safe refuge from storm and danger; Canada, whose land in over a century has not been ravaged by war; whose sons have pursued the arts of peace, and yet have produced "a breed of manly men" whose exploits in battle are second to none; Canada, facing a world of racial and national hatred yet showing how different races can live together in unity. Truly can we say "any day is a fine day in Canada".

We give thanks, too, for the leaders of our Empire in these days of storm and trial; especially for our King and Queen who have built themselves so firmly into the affections of the people; for Winston Churchill who surely "has come to the Kingdom for such a time as this"; and for the unspeakable courage of all those people who are adding a new lustre to the already shining traditions of our heritage. We give thanks for the renewed demonstration that the glory of the Empire is not a glory of geography but of truth and freedom, of justice and civilization, and of all that makes life sweet. For the preservation of this glory no price is too great to pay. We are thankful, too, for the clear thinking President of the United States; for the large body of American citizens who realize that the destiny of our two nations is bound together; and for the apt description of Her Majesty the Queen two years ago, "This great friendly continent where war is impossible".

"England Expects" and England was not disappointed. "Canada Expects"! Canada, where our homes are still intact, where our hospitals are continuing to devise new and better ways to heal the sick; Canada, where "business as usual" is the rule and not the exception; Canada, where everybody can worship God after the dictates of his own conscience; where the freedom of the press and freedom of speech are facts and not mere phrases; where we are still ruled by the free vote of a free people. Canada expects us to give thanks and Canada shall not be disappointed.

—H. G. Wright.





LONDON HOSPITAL OPENS NEW ADDITION

THE new wing of the Victoria Hospital at London, Ontario, which will add 108 beds to the total accommodation, was recently opened. The 7-storey building, which has long been needed, has all the most modern facilities and, with furnishings and equipment will cost approximately $925,000.

The basement floor houses the out-patient, admitting and emergency department as well as the occupational therapy department, the pharmacy, and morgue. Administration and business offices and the radiology department are located on the first floor. The Hamilton-King-Meek Memorial Laboratories are on the third floor. Besides the hospital clinical pathology, all pathology and bacteriology of the medical school of the University of Western Ontario is done in this laboratory. Eye, ear, nose and throat cases, both public and private, are cared for on the third floor, where the paediatric wards are also located.

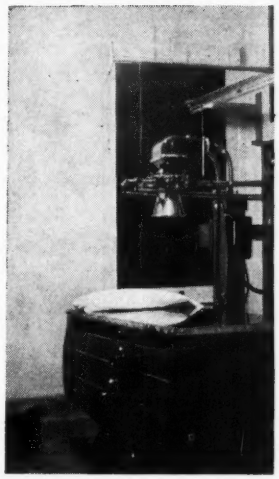
Private and semi-private maternity cases are accommodated on the fourth floor, which is entirely air-conditioned. Labour rooms on this floor are set off by a corridor and double doors. The fifth floor is a general private floor. The surgical department is located on the sixth floor. There are ten operating rooms and all are air conditioned. Galleries between operating rooms enable students to have an unrestricted view of the two operating rooms and loud speakers carry the voices of those in the operating room to the students.

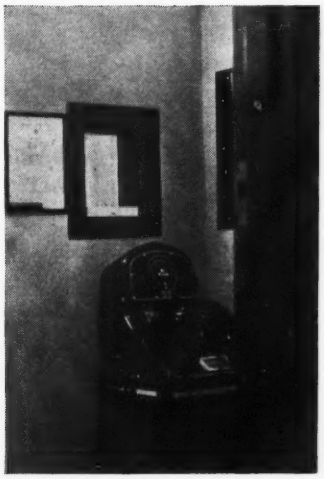
The elevator equipment is the result of a great deal of study and planning by the architects to meet the exacting requirements of this hospital. The elevators are all located in a group near the centre of the building and while each elevator has its own particular field of usefulness, it is so designed that in case any of the elevators are shut down,

The charming private rooms are done in pastel colours.

The sunrooms have modernly designed and comfortable furniture.

A view of the building from the front.





The X-ray department.

the traffic may be handled on one of the other elevators.

On the east side of the corridor is the visitors' passenger elevator and alongside of it is the staff elevator for doctors and nurses. Illuminated signs clearly indicate which of the elevators is normally in use for the visitors so that the staff elevator will be left as free as possible for the doctors and nurses.

Located on the wall between the two entrances at each floor, is a specially designed new type of position indicators which will show immediately to the waiting passenger, at which floor the car happens to be at the time and the direction in which it is travelling.

All the elevators are equipped with Westinghouse Electric motor equipment including an individual motor generator set for each elevator which delivers variable voltage supply to drive the elevator and provides smooth acceleration and deceleration and accurate stopping of the cars at the floors. Each of the elevators also operates on collective push button control system. When the car stops at the floor, the passenger enters and then pushes the button on the car station for the floor to which he wishes to go. When the car starts to travel upwards, it answers each floor call which has been registered, as it approaches that floor, irrespective of the order in which these calls may have been registered.

When the car reaches the highest call registered, it automatically reverses and then takes all the down calls in a similar manner. In this way, the elevator automatically will answer all calls, just the same as an attendant on the car would do but without the necessity of keeping an attendant on the car.

An interesting feature of these elevators is that when the car stops at a floor, the car doors and the landing doors open simultaneously and automatically so that the passenger does not have to touch the doors at all. After a short stop at the floor, sufficiently long to allow the passengers to leave or enter the car, the doors close automatically and the car proceeds on its trip. The doorways are guarded by a new type of protective device which has never been used on any elevators in Canada before. This device is known as the "safety ray" device and consists of a beam of light which is projected across the doorway and so connected with the control equipment that if a passenger intercepts this ray, as he must do in going through the doorway, the doors will automatically reverse should they be closing and thus protect the entering passenger from being hit by the closing doors.

The elevator cabs are of a very pleasing design, with rubber walls so that they will not be damaged by persons or cots. The handrails and fixtures are stainless steel. The lighting is of the concealed type.

Local Plan Affiliates with Ontario Plan for Hospital Care

The Community Hospital Plan, which has been operating in Kingston, Ontario, for the past seven years, has decided that it will affiliate with the Plan for Hospital Care which is sponsored by the Ontario Hospital Association. The new arrangement permits 21 days of benefits for each member of the family, rather than for the family as a whole, and also permits the subscriber to be hospitalized in any hospital in Canada, whereas the local plan gave hospitalization in local hospitals only. Individual and family membership, which has been a feature of the local plan, will be retained, although the usual policy of the provincial plan is to give benefits to employee groups only.

Frank Discussion of Vital Topics Characterizes C.H.C. Meeting

By FRANCES CAMPBELL

ONE of the most widely attended and most interesting meetings of the Canadian Hospital Council was held in Montreal, September 10th and 11th, at the Windsor Hotel. Provincial and regional hospital associations were well represented by both official delegates and interested hospital workers. The provincial and federal health departments sent delegates, and representatives of the three branches of the medical service of the Department of National Defence were in attendance at the various sessions. As much of the discussion centred around the difficulties of the hospitals under war conditions, the presence of the federal health and defence department officials at the meeting provided an excellent opportunity for open and frank discussion of problems which have arisen in connection with government contracts, the construction of defence hospitals, A.R.P. and the rehabilitation of returned men. The generosity of the government in permitting these busy officials to attend the council sessions was much appreciated by all who were present.

Two very welcome guests were Father Alphonse M. Schwitalla, president of the Catholic Hospital Association of the United States and Canada, and Father Georges Verreault, a former president of the Council, who returned to Canada after his work abroad was interrupted by the war.

In his presidential address Dr. George F. Stephens reviewed the work of the Council during the past two years, particularly in its contacts with the Federal Government. Dr. Stephens reiterated a statement from his address of 1939: "The Council has been found to be an excellent avenue of intercommunication between the hospitals and also between the hospitals and governments", and added, "The Council's effort in promoting Canadian unity is no small part of its achievement."

Hospitals and the War

Under this general heading were discussed the personnel problem, as affected by enlistments and the industrial boom; supplies, from the point of view of both availability and rising costs; defence preparations for both civilian and military emergencies; and the construction of defence hospitals.

Some discussion took place as to the extent to which the defence preparations, A.R.P., etc., had extended from the federal director to the local areas. Many communities, as far as the hospitals and the doctors are concerned, are still far from adequately organized. Others have been well organized. Dr. Ross Millar of the Department of Pensions and National Health stated that the government had procured from the Canadian Hospital Council a list of hospitals prepared to take extra patients in a national emergency and that stores of beds and mattresses are located at strategic points all over the Dominion, which the government is prepared to ship to these hospitals on a few hours' notice.

Construction

Rev. Sister Ignatius of Glace Bay, Chairman of the Committee on Hospital Construction and Equipment, summarized some of the important points of her excellent report and Mr. B. Evan Parry of Toronto, a member of the committee, regretted that we are not yet making sufficient use of the new materials and forms in present day construction.

Accounting

The Chairman of the Committee on Accounting, Mr. Percy Ward of Vancouver, in reporting further developments, stated that all provinces but one were now using the C.H.C. basis of statistical return. Mr. James Brady, Chief of the Institutional Branch, Dominion Bureau of Statistics, announced that the Bureau hopes to be able to give an authentic picture of the financial condition of the public hospitals in Canada within two years.

Hospital Finance

Municipal and provincial payments, Workmen's Compensation Board relationships, federal contracts, hospitalization of soldiers' dependants, hospital charges and overseas children were among the important topics considered under Finance, the discussion being led by Miss Ruth C. Wilson, chairman of the Committee. The discussion of

RECONSECRATION PLEDGE
by the Canadian Hospital Council

At this time of peril for our Country, in this fight against the evil powers which threaten to engulf the world, conscious of our duty towards Canada and towards our fellow men, we solemnly pledge before Almighty God that we shall do all that lies within our power and deem no sacrifice too great, to bring about victory of our arms, that right may triumph, that justice may prevail and that a righteous peace may reign throughout the world; to this end we reconsecrate ourselves, with faith, with courage and with the knowledge that, though the path be hard and the day be dark our effort can not fail.

federal contracts and rates raised the question of *central buying* which was cited as an advantage on the side of the government hospitals. In this connection Dr. Ross Millar suggested that hospitals in one city could group together to buy on the same basis that the government uses, and that they could also economize by using a common drug and appliance book which would limit doctors to those drugs and appliances listed.

Rehabilitation

The rehabilitation of returned men is a pertinent question. It was recommended by Dr. Stephens that more publicity be given to the work of the federal committee and local officers appointed to look after this work. It was announced at the meeting that where many soldiers were stationed and where there was no federal hospital, the D.P.N.H. would purchase equipment for physical rehabilitation and loan it to the civilian hospitals.

"The Canadian Hospital"

The announcement by the Editor of THE CANADIAN HOSPITAL, that Mr. C. A. Edwards, the publisher, had generously donated the publishing rights of the journal to the Council, was received with appreciation by the meeting.

Nursing and Nurse Education

In connection with V.A.D. training, which has been a vital question for some months, it was reported that the two Montreal hospitals (the Royal Victoria Hospital and the Montreal General Hospital) chosen to give such training as an experiment were very well satisfied with the results of the course as far as it had gone. Important in this connection was the announcement made by Dr. Ross Millar that the Department of Pensions and National Health is planning to take on trained women volunteers in their hospitals because of the difficulties in getting orderlies, and that the Department of Defence may reconsider its decision of some months ago not to accept such workers.

The shortage of graduate nurses and of applicants for entrance to the schools of nursing is a serious one, particularly in Montreal and Nova Scotia. According to Miss Marian Lindeburgh of the McGill School for Graduate Nurses, a meeting is to be held shortly to consider this situation and to consider plans for centralized teaching or pre-nursing university courses as a solution. It was suggested by Miss Frances Upton that a "campaign" for enrolment in the nursing schools on a patriotic basis might be one solution.

Miss Ruth Wilson of Moncton and Dr. Ross Millar, Department of Pensions and National Health, "bury the hatchet" most amicably.

Right—Mr. Percy Ward of Vancouver, Chairman of the Committee on Accounting.

The importance of unity among the hospitals on the question of health insurance was stressed by Dr. J. H. Holbrook of Hamilton, chairman of the Committee on Health Insurance, in view of the increasing agitation for a national scheme of health insurance. The Secretary recommended that hospitals make use of the bulletins on this subject published recently by the Canadian Medical Association.

The recommendations of the Special Committee on Nomenclature were announced to the meeting and referred to the Executive.

A final suggestion at the end of a crowded and interesting programme, which came from one of the federal government representatives, was that the Council meetings in future be held over a period of three or four days in order that the delegates might obtain the full benefit of such a gathering. It was agreed that the next meeting, in 1943, should be held in March rather than in September.

Incoming Officers

President, Dr. George F. Stephens, Montreal; 1st vice-president, Mr. H. G. Wright, Saint John, N.B.; 2nd vice-president, Dr. A. K. Haywood, Vancouver; executive members—Dr. A. F. Anderson, Edmonton, and Mr. J. H. Roy, Montreal.

Obiter Dicta

The Montreal Conclave of the Canadian Hospital Council

THOSE who were fortunate enough to attend the September meeting of the Canadian Hospital Council in Montreal must have been convinced if that were necessary, of the tremendous value of such a meeting. In his Presidential Address, Dr. Stephens struck the keynote of the sessions when he stated that the main purpose of the meeting was to discuss "ways and means whereby our hospitals and their personnel can be of most service to the Empire and the cause of Freedom".

By virtue of the nature of the programme, which was essentially a panel discussion on a wide range of vital up-to-the-minute topics, a maximum use was made of the time available and all present had an opportunity to express their views. The attendance of delegates from coast to coast and the large number of representatives of the federal and provincial governments clearly indicated the degree of importance which is placed upon these discussions. Study committee reports were of a high order and will make valuable additions to our hospital literature when printed and distributed.

Naturally issues related to the war effort dominated the stage, but not entirely so, for other topics, such as health insurance, nurse education, accounting methods and hospital finance aroused considerable interest. In an effort to save the time of the delegates, the programme has always been confined to two days, even less this session for the train schedules from the west did not favour a morning programme on the first day. However, the increasing interest in the council deliberations and the importance of so many of the topics discussed would suggest the wisdom of seriously considering the lengthening of the sessions to three days. By so doing ample opportunity would be provided for a more thorough discussion of the topics presented.

Academic Recognition of Hospital Administrative Leadership

IT WAS pleasing to note that the fine leadership given to hospital administration by Mother Audet of the Hotel-Dieu, Campbellton, N. B., has been recognized by an honorary degree from Sacred Heart University, Bathurst, N.B. The late Miss Jean Gunn a few years ago received an Honorary Doctor of Laws degree from the University of Toronto for her outstanding contribution to nursing education. Dr. M. T. MacEachern has also been honoured with an honorary Doctorate in Science, and Miss Jessie Turnbull of Pittsburgh, a noted leader in the hospital and nursing fields, has been given a Doctorate in Social Science by the University of Pennsylvania. This spring, Dr. Charles A. Wilensky, Administrator of the Beth Israel Hospital at Boston received an honorary degree from Harvard in recognition of his great work in public health and in hospital administration in New England.

This is as it should be. Universities have honoured men and women in all walks of life, some for reason of intellectual achievement, some for public service and some for properly directed loosening of the purse strings. In view of the importance of hospitals to community welfare, it is fitting indeed that some of those who have contributed so extensively to their development should be honoured in this way.

Operating Costs of Hospital Care Plans

IN evaluating hospital care plans, or any other type of voluntary insurance, we are inclined to lay stress on the size of the enrolment, on the scope of the benefits offered, or on the size of the reserve. We often do not lay as much emphasis as we should upon the relationship of administrative costs to the expenditures as a whole. It is an expensive experiment, despite the desirable factor of insurance coverage, if too high a percentage of the premiums is deflected into overhead and does not return in service to the insured group.

We know of one plan where the private group of organizers take one third of the income for administrative expenses. This is quite uncalled for. Costs are naturally high during the organizing period, but once that period is over most plans are able to operate at from 15 to 20 per cent or even lower. Speaking at the Ohio convention this year, Dr. R. H. Bishop, Jr., Director of the University Hospitals in Cleveland, stated that 10 to 12 per cent should be sufficient for an efficiently managed plan. This would apply of course to large plans in industrial areas where payroll deductions could be made. Overhead can also be low in small-centre single-hospital plans where a small honorarium to the secretary and postage may be the main items of expense. Here, how-

ever, the usual lack of reserve and the hazard of insuring a small group make such plans a dubious experiment. Medium sized plans, particularly if in a non-industrialized area and accepting individuals, can usually justify a higher overhead than suggested by Dr. Bishop.

The plan in Cleveland actually operates on an 8 per cent basis. This plan has enrolled 365,000 subscribers, which figure represents over 35 per cent of the population. This year the Cleveland Hospital Service Association allocated its income: 8 per cent for operating expenses; 7 per cent for reserve; 85 per cent for hospitalization of members. This is a remarkable example of efficient administration and indicates that in well-managed plans the subscribers' interests are exceedingly well guarded.

Undermining Confidence

AT a time when Canada is, or should be, bending every effort to win the war, it is hard to understand why the sound ruling of both the Foreign Exchange Control Board and the Department of Customs should be overruled to permit a Windsor, Ont., person, described by the press as a "well-known character", to import slot machines in such number that the duty alone amounted to $11,000. Every hospital is inconvenienced by the rigid prohibitions of the War Exchange Conservation Act, even to the point of curtailing service to the sick, but we are more than willing to co-operate if by so doing we can hasten victory. Although both the Department of National Revenue and the Foreign Exchange Control Board had refused to recognize any necessity for the importation of these repeatedly condemned gambling devices and the Department of External Affairs had supported this decision, the import licence was finally ordered. The claim put forward that this shipment had antedated the enactment was not accepted by investigating officials.

It is not conducive to confidence in the Government to have the spirit of a wise Act and the decisions of conscientious Department and Board officials disregarded simply because some person puts on a little political pressure to enable him to import devices declared illegal by federal enactment and destined to divert precious dollars from war savings certificates to personal profits. Because it is actions like this which do so much to undermine public confidence and morale, it would seem highly desirable that a satisfactory explanation, if there be one, be given to the public.

Gifts of Improvisation

ALL the records of the campaign in the various fields of operation in Africa are agreed in testifying to the resourcefulness of the commanders in meeting problems in a strange environment. It is an attribute, which is commonly regarded as the sailor's, as the handyman's, but the Army and Air Force have equally shown their gifts of improvisation. In fact, the correspondents have found its existence among a small expedition of General de Gaulle's army, who unexpectedly cut off an Italian force considering itself safe from attack. Enterprise and initiative under such conditions earn well-deserved plaudits. The record is rapidly conveyed to all quarters of the globe, especially when the forces include a large proportion of men from the Dominions.

Nevertheless, "gifts of improvisation" is a singularly apt phrase to describe what is often found in hospital and medical work. Time after time in the records of medical research it is the man with crude equipment, but possessed with the gift of improvisation, who has produced some brilliant result. Scholarships and other means of reducing hardships have reduced the stimulus to initiative and resource. In hospital work there may be found an official possessing this gift, which is applied to the daily task with great benefit to the smooth working of some department. He may be called a clerk of works or some similar title, like Mr. H. Hill, of the Bristol Royal Infirmary, whose contribution to this number provides examples of the gifts of improvisation. It is specially called for in time of emergency, and many of the dilemmas in which hospitals have been placed by air attacks have led to its appearance among nursing and other members of the staff. Perhaps its most brilliant display has been in prompt measures without thought of self for the protection of the patients, and in that sphere the porter staffs have accomplished deeds of heroism with prompt resourcefulness.

It is however, the clerk of works, or someone holding an analogous position, who in peace time is given many opportunities to exercise this gift. The contribution of a man of that type to the efficient working of a hospital is hardly known to the general public, but scarcely a day passes without someone within it having occasion to be thankful to him. A member of the medical staff wants some gadget made to carry out a novel form of treatment. The engineer or clerk of works is called to the rescue. His great gift is his ability to assimilate the nature of the need and, after an interval, sometimes for consideration, to improvise the piece of equipment to meet it. In hospitals where there is no such man the only alternative is to call in the representative of a firm who, with the best will in the world, can neither supply what is necessary so efficiently nor so economically. The man on the staff is aware of all the factors in the situation, and above all, knows the whole contents of the hospital with an unsurpassed devotion, so that his gift of improvisation is cultivated to the nth degree.

Even to those who know his worth this type of man becomes so much part of the life of the hospital that they take all his activities as a matter of course. The committee may realize that he saves the hospital hundreds of pounds a year, yet they are quite content to pay him a small fraction of what he can actually show has been saved on necessary expenditure. A gift of improvisation is not a gold mine to its owner, but he has his reward in the genuine appreciation of all those who are aided by it in their ministry of healing.

—Hospital and Nursing Home Management.

The Hospital Buyer and the Salesman

ONCE upon a time there was a salesman who was hired and put in a territory by a certain large firm. The salesman made lots of calls and apparently tried hard, but while the reports came in, they were not accompanied by any orders. In detailing the results of each call, the salesman would go on to elaborate on how nice Mr. So and So was to him and what a good visit they had, and while he didn't get an order from Mr. So and So, the reception he received was "a feather in his cap". After about four or five months with still no orders but plenty of feathers, the sales manager wrote this gentleman and told him that inasmuch as his hat was now apparently pretty full of feathers he should pull them out and make a tail and pair of wings for himself and fly away home. "Unfortunately", said the sales manager, "we are running a hospital supply business and not an aviary or a pillow factory".

Selling is not conquest, it is co-operation—both parties to the transaction must play their part fairly and honestly.

Any salesman who is worth his salt to himself and his company is just as interested as the hospital buyer in seeing that his customers are satisfied and get value received for their money. He is, after all, only human and responds to the same gestures of courtesy and good-feeling as you hospital administrators yourselves. When these gestures are extended to a salesman you will always find him willing and anxious to co-operate on matters involving infinitely small purchases as well as large ones.

A good salesman knows that competition on standard merchandise automatically tends to find its own price level; simple arithmetic has taught him that even a 5 per cent cut in the price of an article requires almost 11 per cent more volume to support the cost of manufacture and distribution, whereas a 10 per cent cut in price requires 26 per cent more volume.

Higher standards of buying involve not only the quality of the article but the integrity of the producer, his salesmen, and his distributors, their value to the hospital field as a whole within their sphere of operation. These are the fundamentals a buyer should consider above the slight price factor which is always the prime lure of the itinerant merchant.

The hospital administrator should learn to know the salesmen calling on him in the same way the salesman is taught to know his product. With little effort you can soon learn which men know their stuff, which will help you in small things as well as large, and which will give you your money's worth.

A good salesman calling on you is an excellent clearing house for good ideas and helpful suggestions. Remember, he has seen a lot of material and equipment used and tried in various institutions and with varying degrees of success or failure.

Beware of any salesman who knocks his competitor, either the house or its personnel. He is usually the one who will be of the least value to you. Sometimes young, green salesmen fall for this method of approach thinking they are making heroes of themselves, but in an older man it is almost inexcusable. Pointing out his honest belief in why his equipment is better is one thing, but the unsupported slur or derogatory remark is something else.

Try to be as reasonable as you can in handling complaints with the salesmen who sell you merchandise. With the best of equipment or supplies, things are going to go wrong occasionally. If it is standard merchandise that is defective the manufacturer and dealer are just as anxious to repair or replace it as you are and you will be protected. Be fair enough to give the salesman as much data as possible about the trouble you experienced.

Do not discard without consideration the honest suggestion of a salesman that the cause of the trouble may not be with the device or supplies but in their improper use.

If you have trouble with merchandise which you insisted on buying at a price, over the objection of the salesman who sold it to you, take that into consideration too.

Occasionally some buyers, in an attempt to get a better deal, will tell a salesman that So and So have offered him the same merchandise at lower prices. Once in a while this procedure is successful, but this habit has a way of bouncing back on the buyer at some future date.

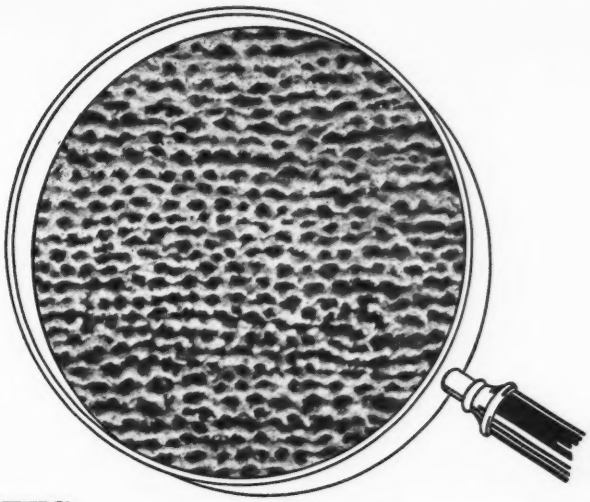
The Buyer's Creed

1. Do I show reasonable friendliness and courtesy, and make a real effort to know and understand the men who call on me regularly?
2. Do I take the full advantage of what I can learn from them?
3. Are the manufacturers and dealers with whom I do business reliable?
4. Do I fully appreciate the part a distributor plays in enabling me to obtain standard merchandise at fair prices?
5. Do I actually take quality and service into consideration when I purchase or am I kidding myself on that old bromide—"just as good"?
6. Are the complaints I make on material and merchandise always reasonable? Was the failure of the material due to the merchandise itself or was it improperly used in my hospital—or is it something I insisted on buying because it was cheap?
7. Do I refuse to allow personal friendships to close the door to fair comparison?
8. Do I refrain from misrepresentation in an attempt to get a better price?

Excerpts from a paper by G. P. Snow of the Cutter Laboratories at the 1941 Carolinas-Virginias Hospital Conference. Courtesy Southern Hospital.

Orthopaedic Unit in Scotland

The Canadian Red Cross, in co-operation with the Canadian Nurses Association and the Canadian Medical Association, has organized in a civilian orthopaedic unit to serve in Scotland. Organized in response to a request from the Scottish Board of Health, the unit will consist of 17 nurses and 10 doctors and will serve in a civilian hospital to help relieve pressure on the medical profession.



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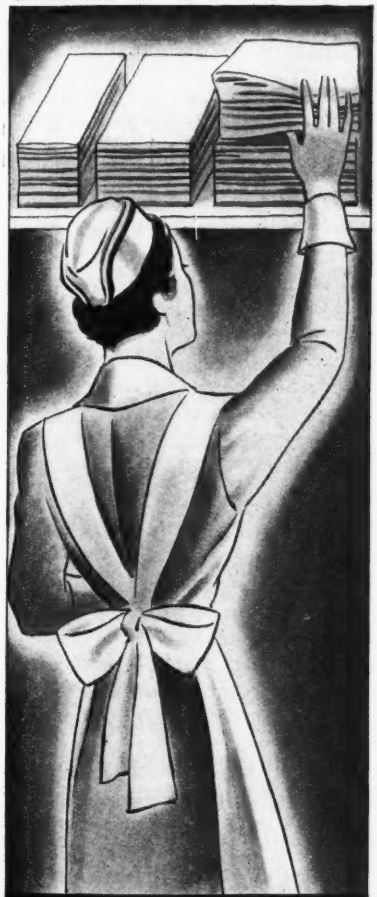

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Hospital Social Problems Affected by Present Trends

Contributed by
MISS CHARLOTTE WHITTON, C.B.E., M.A., D.C.L.
to Report of C. H. C. Committee on Finance

(1) Problems Centering about Dependants of the Men in the Forces

DEPENDANTS' allowances are on a much more generous scale than in the last war, and begin upon enlistment, or, in the case of drafts, upon selection. However, like the average income of the average worker, they cannot contemplate all exigencies and, when needs for hospitalization arise, a problem is created. As far as we can see from the reports of the social agencies, these, in turn, raise problems in handling along two or three lines. If the illness of the mother or child is not extremely serious, an effort is made to meet it where facilities exist by the use of the *hospitals' out-patient department*, or by *community clinics*, and the use of the *home nursing services of the V.O.N.* Where the mother is the person concerned, the *visiting housekeeper* is also being enlisted in an attempt to hold the line. The social agencies report a great disinclination on the part of the mother, either to enter hospital herself, or to have the child go, unless this is absolutely necessary. Because the father is away from home she worries either over being out of the home herself or, if the child is out, the absence involved in going to the hospital to see the child. In many of the cases we find also that a combination of the out-patient service of the hospital with the nursing or the housekeeping service means less outlay for the community as a whole than hospitalization, unless this is absolutely indicated.

Where hospitalization must be provided, grave financial problems arise; in many cases families have followed their enlisted members and are out of the unit of their residence. In the majority of cases there is not any accumulation of savings or any assurance of income beyond the allowance to assure payment of hospitalization. Also there is a disinclination, on the part of the general community and many of the families, to have soldiers' dependants treated as public cases, though, as a matter of fact, large numbers of them were so treated when the men now in the forces were either unemployed or in civilian occupations.

This whole situation is one in which the hospital interests and the social welfare interests are jointly concerned. The Canadian Welfare Council has been endeavouring to find some way for the assurance of supplementary funds, not on a campaign basis (which would increase the demand and mean more cost and more duplication of effort) but through some central fund administered under trustees for emergency aid both to this type of case and to dischargees not eligible for military care.

The Canadian Hospital Council has been urging the Federal Government to set up a nation-wide plan of group hospitalization so that by a small individual contribution per month soldiers' dependants could be relieved of the worry over the cost of hospitalization. If this monthly premium, which would not be large, could be collected centrally, thus materially reducing the costs of administration, the cost of such a plan would be a very small one for individuals. This money could either be deducted from the monthly cheques sent to the dependants, or could be provided by the government in lieu of increased allowances for the rising cost of living. Such a national plan would be infinitely better than dependence upon local plans, as the majority of centres of population in Canada do not have any hospital care plans in which the dependants could voluntarily enrol.

(2) Withdrawal of Dominion from Unemployment Relief

The withdrawal of the Dominion from participation in aid to the unemployed will also affect pressure on hospital facilities. Several of our agencies report pressure already on hospital accommodation, especially in smaller centres where there is a tendency to use the public ward for chronically infirm unemployable cases rather than cases truly needing hospitalization. It is true that no Dominion funds were ever available for hospital or medical care. On the other hand, however, the availability of federal funds for unemployment aid made it indirectly possible for several of the provinces and municipalities to provide medical care. Now, with the withdrawal of Dominion support and the cutting in of war needs on provincial and municipal revenue, a serious situation threatens for those unemployed resting on provincial and municipal or, in some provinces, entirely on municipal funds; and also for all other categories such as Mothers' Allowances and general relief cases aided by provincial and municipal funds but without provision for hospitalization.

(3) Care of Overseas Children

Overseas children in Canada present yet another problem. There were 1,532 moved under the joint government schemes, and these will be assured in respect to payment of hospitalization costs through the agreements between the social agencies, the provinces and the Dominion.

However, there are 2,057 children who were destined to private sponsors, some in school groups, others individually. With exchange restrictions on sterling no remittances are possible for these children and sponsorship has been breaking down; in many other cases the family is able to give shelter, food, clothing and schooling but is in no position to meet unexpected hospitalization.

More difficult still is the situation in respect to 2,323 children who came over in the care of their mothers, the latter numbering 700 to 800. They, too, entirely lack funds and

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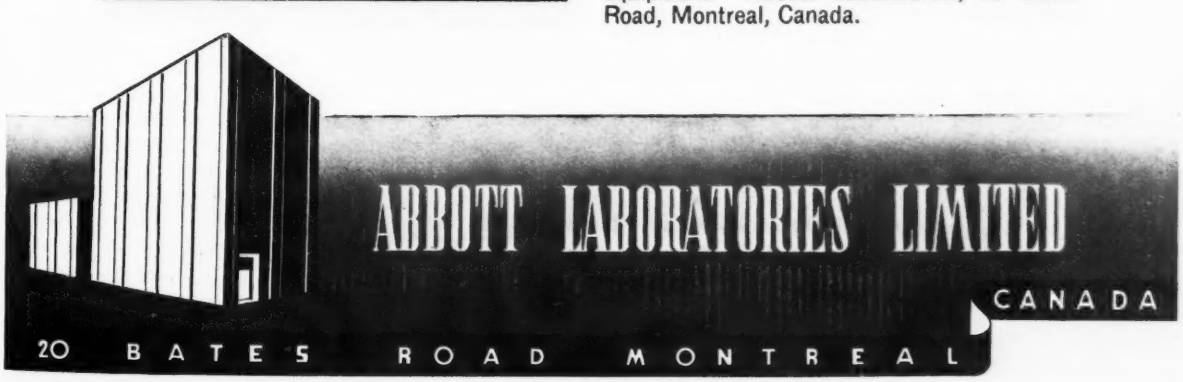


The beautiful Meredith home has been presented to the Royal Victoria Hospital, Montreal, by Lady Meredith, and will serve as a nurses' residence. Lady Meredith is head of the Women's Auxiliary and the late Sir Vincent Meredith was president of the hospital from 1913 until his death.

have been dependent upon private sponsors and resources. Many cases of heavy hospitalization costs have come to the attention of our social agencies. The agencies have really made a remarkable job of getting adjustment and placement for most of these women, while the I.O.D.E. is providing supplementary and interim aid in collaboration with the existing services. However, here too a grave question of hospitalization awaits adjustment.

(4) Effect of Wartime Industrial Mobilization

The social services are greatly concerned about social problems arising out of conditions of to-day, and in these they see out-patient and hospitalization problems as looming large. These problems are the result of the tremendous shift of population to centres of industrial production and to new war boom communities. Public opinion is all heated up in respect to housing, and plans are under way for erection of housing units. However, this will raise new and broader problems if housing is looked upon as the sole community need because two essentials, schools and health and hospital facilities as they now exist, cannot possibly meet the pressure of thousands of new wage earning units. There is a grave problem here as to whether new units of schools or hospitals should be erected when the demand is likely to be purely temporary. Is a housing project the simple answer? Is there not reason to explore the wisdom of having hostels for employees on a temporary basis and providing dependants' allowances and transportation allowance for these workers so that their families and dependants will remain in the communities where shelter, health, schooling and other facilities can handle them and where, as a matter of fact, they are likely to be permanently located and to which they are likely to return with the cessation of such activities as war industries, special training camps, etc.?

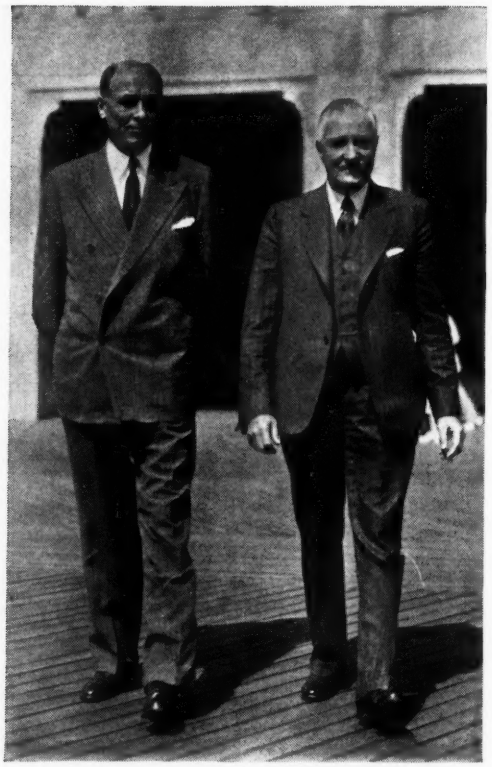
(5) Hospital Out-Patient Service and Social Service

All these problems reinforce the great community of interest that there is between the social agency proper, whether under public or voluntary auspices, and the hospital in that border line between life in the community and care in the hospital.

It seems that there is an entire area here on which there has been inadequate thinking in terms applicable to all but the very largest cities in Canada. Hospital administrators know that the removal of an individual from a home to a hospital often creates such grave social problems as to become a major factor in the health and mental care of the patient. They know also that much of their skill and resources are expended, only to be lost when discharge and convalescent conditions are such as to frustrate the benefits of some of the treatment. In the smaller cities, and in the more thickly settled rural areas served by one or two central hospitals, there is a rich field for co-operative partner-

(*Continued on page* 64)

Defence Preparations Keynote of Atlantic City Meeting



EVERY four or five years the American Hospital Association returns to Atlantic City for its convention, an arrangement which proved if anything more popular this year even than in previous years. The unsurpassed facilities for the exhibits in the mammoth exhibit hall, the fine meeting arrangements and the glorious beach combined to attract a well-above-average attendance to this setting for an outstanding programme. The Canadian delegation, though not as large as in pre-war days, took its place in the House of Delegates and faithfully attended the many sectional meetings.

Other organizations meeting simultaneously were the American College of Hospital Administrators, the American Protestant Hospital Association and the American Association of Nurse Anesthetists.

"Preparedness"

Although the programme was well varied, the outstanding session was that on "Preparedness". A coterie of hospital, nursing and federal authorities provided a symposium which covered the subject from many angles. Although we in Canada have had a two-year start, it is very apparent that this question of defence has been taken very seriously to the south. Dr. Winford Smith of Johns Hopkins, Chairman for Hospitals on the Council of National Defence, urged that nurse enrolment be increased 15 per cent. He emphasized,

Above. Dr. A. K. Haywood was the proudest man on the Boardwalk when one of his "boys", Dr. Basil C. MacLean of Rochester, N.Y., (left) was installed as A.H.A. President.

Left. The new President-elect of the A.H.A., James A. Hamilton of New Haven (right) laughs while he can with Trustee Frank Walters of Denver and Mrs. Hamilton. Dr. Chas. A. Wilensky of Boston, the noted public health and hospital authority is on the left.

Below. Dr. Wm. H. Delaney of Quebec (right) ponders this one by Dr. Miles Brown of Hamilton, while R. E. Heerman of Los Angeles does a spot of pondering too.

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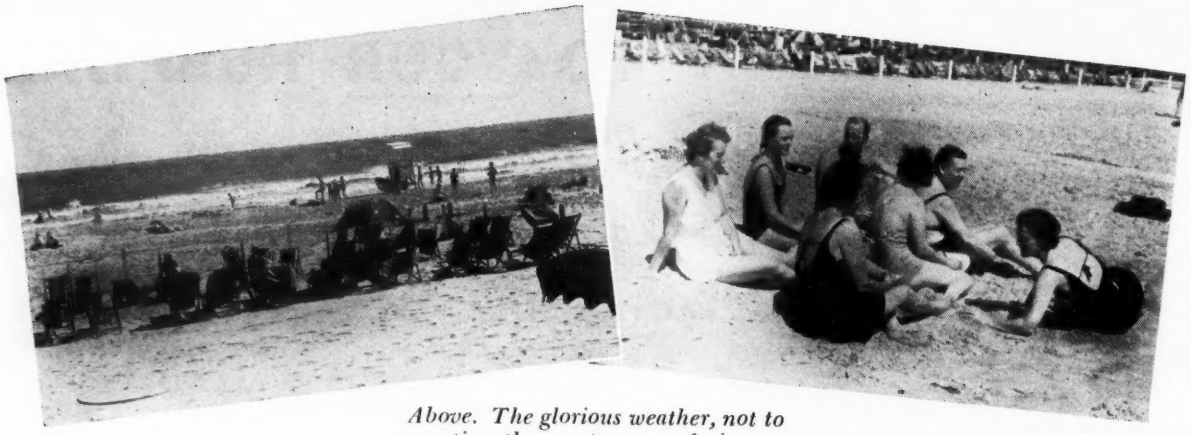

Above. The glorious weather, not to mention the company, made it easy to play hookey.

too, the necessity of being prepared for fire and explosion in defence industries.

Priority Problems

Another subject that caused endless discussion at Round Tables and in lobby corners was that of "priorities". The exhibitors reported themselves particularly hard hit and many of them have difficulty filling hospital orders. The Hon. Milton H. Luce of Washington, Administrator of the Health Supply Section, O.P.M., was present to explain the priorities system. All industry is listed by priority. Hospitals were formerly B3 but are now raised to A10 listing. This means that their orders have priority over orders of lower classification but not over one listed as A9. The aircraft industry is "tops" with an AA rating. Hospitals requiring equipment for scientific research related to the war effort can get an A2 listing for such orders. Although sound in principle, it has caused considerable inconvenience and delay, bringing the war very close to many people. As Mr. Luce warned, "From now on you get not what you want to buy but only what is absolutely necessary that you have".

Hospital Care Plans

Representatives of the Blue Cross and other hospital care plans held a number of sessions and did much to co-ordinate plans for their future development. Among those present we noted representatives from Winnipeg, Toronto, British Columbia and the new plan in Montreal.

One of the revisions in the A.H.A. by-laws permits the hospital care plans to become members of the American Hospital Association as plans, and the plans as a whole are to have representation in the House of Delegates. This is a distinctly progressive step, as it unifies the hospitals and the plans into a co-ordinated policy of development.

(*Continued on page* 80)

Below. Commiserating with each other here are the two incoming Presidents, Dr. Basil C. MacLean of the A.H.A. and Dr. Lucius Wilson of Philadelphia, the new President of the American College of Hospital Administrators.

Centre. Three does seem like a crowd here, too, but these three Canucks are thoroughly enjoying it. David Bell of Metal Craft, Grimsby, Harry Haynes of Simpsons, and Arthur J. Swanson of the Toronto Western Hospital.

Below. Dr. Otho Ball, publisher of Modern Hospital (left) talks Defence Preparation with Dr. Robin C. Buerki, the new Dean of Graduate Medicine of Pennsylvania.

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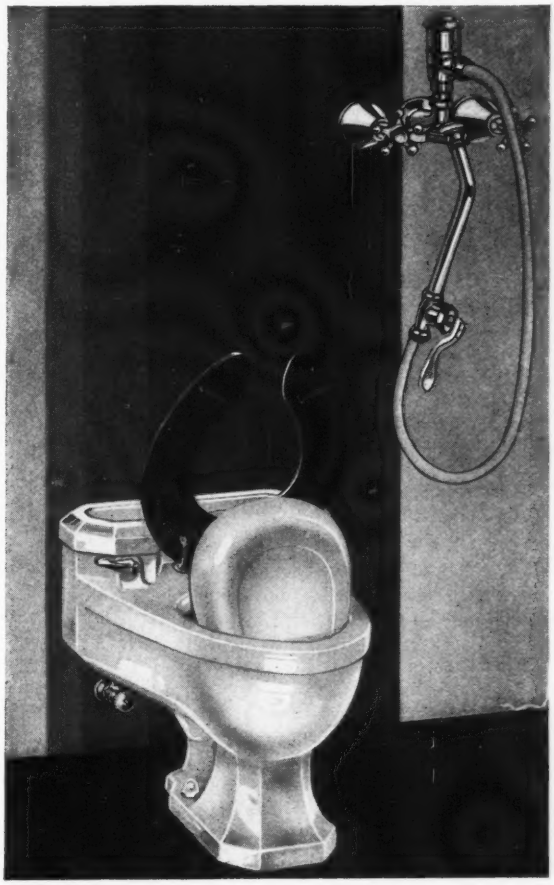

T/N Toilet showing positions of bed pan when inserted between lugs. At right is shown bed pan cleansing fixture No. C7450, equipped with vacuum breaker and 3/8" rubber hose, with lever-operated self-closing stop and rubber-bound spray.

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With the Hospitals in Britain

By "LONDONER"

C. E. A. Bedwell

Dear Mr. Editor,

War conditions, as you no doubt are finding (as we have) make their contribution to some of the standing problems which are always claiming a certain amount of attention. We may hope that at the same time they may render some assistance in their solution. These philosophical observations are prompted by the position in respect to accidents, road and industrial.

Road Traffic Accidents

At the beginning of the war there was an inclination to blame the 'black-out' for the increase in the number of accidents on the road. But when the brighter and longer days came the numbers still soared and it became necessary to look in other directions for a cause. Perhaps the psychological factor is the most important. The distraction of current events is liable to have its effect upon driver and pedestrian so that concentration on the road crossing is not adequate to avoid mistake.

Industrial Accidents

On the other hand the Chief Inspector of Factories has been able to provide a more satisfactory report in respect to industrial accidents. In view of the increase of employment brought about by the extension of the war industries he was able to say "that the increase in non-fatal accidents is not greater than the increase in 'man hours' worked." There was, however, a deplorable addition to the number of fatal accidents. This was due in the first instance to a failure to heed the Government warnings to black-out the buildings. Then the work had to be undertaken in a hurry and in consequence many fatalities occurred in the rush. The number in September, 1939, was the highest on record and many were due to men falling through roofs.

Compensations

In the factories war conditions have provided a really useful development. Dr. Bridge, the senior medical Factory Inspector, observes in his report that "first aid in industry has received an impetus from the intensive preparations for Civil Defence." This is an advance which remains permanent and so will provide early and satisfactory treatment for accidents.

The casualties from air raids through falling masonry and in other ways have provided a high proportion of fractures. Once again this has emphasized the importance of having organized centres for the treatment of fractures and the Minister of Health has taken steps to provide them in the emergency medical service.

Fracture Clinics

More than six years ago the British Medical Association published a report which aroused public opinion to the inadequacy of the organization in this country for the treatment of fractures. It led to the appointment of an official committee by the Home Office, the Ministry of Health and the Scottish Office. They presented an admirable report setting forth a complete scheme for the organization and functions of a fracture department staffed by a specialized team of surgeons and nurses with lay assistants engaged in the rehabilitation of the patients. The finance presented difficulties as the local authorities were not prepared to shoulder the whole burden and the voluntary hospitals considered that they were entitled to remuneration for undertaking work financially beneficial to insurance companies and others.

Looked at from a business and commonsense point of view the simplest and most satisfactory way of dealing with the expense is to avoid it altogether. Certainly no one can dispute that a large percentage of accidents on the roads and in the factories are preventable. The Committee referred to above observed that "the financial loss to the community resulting from injuries by accident must be enormous" and pointed out that the first way to diminish the loss was to prevent the accidents. Workmen's compensation alone costs £13,000,000 a year. However, admitting the existence of the people requiring treatment there is a clear obligation on the hospitals to provide it so efficiently as to restore the patient as rapidly as possible to full working capacity. For the time being provision is being made in the emergency hospital service and a certain number of other centres provided for special sections of the community like the Seamen's Hospital at Greenwich and some others in large voluntary and council hospitals.

An Accident Hospital

The latest development in this connection is the conversion of the former Queen's Hospital in Birmingham into an accident hospital. When the Hospital Centre, now the Queen Elizabeth Hospital, was established Queen's was supposed to have come to an end and in fact its endowments were transferred to the United Hospital. Now further use has been found for a century old institution. The Nuffield Trustees have made a capital grant for its establishment as a specialized centre for the treatment of accidents. Employers of labour are appreciating that this is a paying proposition and subscribing on the basis of two shillings a year for each employee.

Nevertheless in the course of reorientating some of the ideas to which we have clung tenaciously in the past perhaps we shall fix our minds on avoiding accidents rather than treating them. Otherwise we might just as well look forward to an existence in air raid shelters instead of a time when we shall be free from attacks from the air.

Seasonal Factors in Construction

From the Report of the C. H. C. Committee on Construction and Equipment

BUILDING operations should start as soon as weather conditions permit, especially if the building is to be of considerable size and of brick construction, in order that the brick work of the exterior walls may be completed before cold weather sets in. It will certainly be more economical to do as much construction work as possible between early spring and late fall, as freezing weather is a hazard to wet mortar and concrete, exposed water pipes, etc. Also, the cost of temporary heat in winter is a considerable expense.

The usual custom among owners and committees is to call for tenders just before the time fixed for building operations to begin. If it is then found that the tenders run too high, much valuable time is lost making changes in the plans and specifications, before the placing of the contract and the commencing of operations. Every day thus lost carries the work so much closer to, or even into, the cold weather, the result of which may be the freezing and thawing of mortar, thereby causing early deterioration and crumbling of the exposed and unhardened mortar, unless necessary precautions are taken —precautions which add to the cost of the building.

Important Features of Brick Walls

Since brick is used to a great extent in the building of hospitals, some important points may be stressed regarding the exterior brick walls. The proper construction of brick walls involves many things besides the laying of one brick upon another, with a bed of mortar between. The points in construction required to obtain strong and durable walls, and the precautions to be observed to prevent settlement and cracks, and to adapt the work to the purpose for which it is intended, must be taken fully into consideration.

The laying of brick should be carefully watched, as there is a tendency on the part of many masons to slight this work. Brick should not be merely laid, but *each one should be pressed down in such a manner as to force the mortar into the pores of the brick and to produce maximum adhesion.* The bricks should be laid down with a "shove joint", that is, the brick should first be laid so as to project over the one below and to be pressed into the mortar, and then be shoved into final position. Backing brick in the interior of the wall should be laid in full beds of mortar, filling end and side joints in one operation. The bedding for the outer tier of back brick should be curled against the back of the facing tier, to form a cove partially filling the collar joint. The filling of all vertical joints which are not filled completely as the bricks are laid should be completed by slushing — filling all cavities throughout the wall. This operation is simple and easy with skilled masons — if they do it — but it requires persistence to get it done. The mortar for the bed joints of the facing tier and inside tier should be spread to a uniform thickness (not furrowed), and the ends of the stretcher brick and the sides of all header brick should be coated with mortar before laying.

The inside face of the facing tier should be pargeted thoroughly. The joints of the outer face should be tooled to hard concave joints as soon as the mortar becomes thumbnail hard.

Tricks of the Trade

Masons have a habit of laying bricks in a bed of mortar, leaving the vertical joints to take care of themselves; throwing a little mortar over the top beds and giving a sweep with the trowel which more or less disguises the open joints below. They also have the habit — after the mortar has been applied — of drawing the point of the trowel through this bed, thereby making an open channel with only a sharp ridge of mortar on each side (often throwing some of it overboard), so that if the succeeding brick is taken up it will show a clear cavity, free from mortar through the bed. This will enable them to bed the next brick with more facility, and avoid pressure upon it to obtain the requisite thickness of joint. Another common but improper method of building brick walls is to lay up the outer stretcher courses between the header courses, and then to throw mortar into the trough thus formed, making it semi-fluid by the addition of doses of water, then throwing in the brick bats, (sand and rubbish are sometimes substituted for brick), allowing them to find their own bearing. When the trough is filled, it is plastered over with stiff mortar, and the header course laid and the operation repeated.

In cases where air spaces are called for in brick walls, the greatest vigilance should be exercised during the progress of the work to guard against the carelessness of workmen who will, if not watched continually, fill this space with rubbish and mortar, thus defeating the object for which the air spaces were intended.

The same vigilance over the construction of *chimneys* is absolutely necessary. The neglect of it may entail inconvenience and expense in the removal of obstructions which may seriously impair their efficiency.

Medium absorption and *high absorption* brick should be wet before laying, except in cold weather, but not to the point of saturation, as they would be incapable of absorbing any moisture from the mortar, and the adhesion between the brick and mortar would be weak.

Low absorption brick should be kept dry on the stage and laid dry. If these bricks are laid wet they have a strong tendency to slide on the beds, especially the outer 4" work. When this condition exists the masons will invariably fail to slush or fill the joints between the outer 4" and the backing brick, owing to the tendency of the mortar to force the brick outwards.

Mortar

Numerous investigators have listed the desirable properties of masonry mortars. There is substantial

Q. *But, doctor, is it all right to leave the peas I don't eat in an open can?*

A. *From the standpoint of health, there is no reason why peas, or any canned food, should be put into another container.* (1)

(1) For some obscure reason many members of the general public persist in believing that an open can is not a safe food container. Public health authorities have commented on this fallacy in these words:

". . . Thousands of housewives are firm in the faith that canned foods ought to be emptied as soon as the can is opened, or at least before the remainder of the food goes into the refrigerator . . . Whether in the original can or in another container, the principal precautions for keeping food are—Keep it cool and keep it covered." *American Can Company, Hamilton, Ontario; American Can Company, Limited, Vancouver, B.C.*

Courtesy *Halifax Herald.*

A group of delegates at the annual meeting of the Maritime Conference of the Catholic Hospital Association held at Halifax, the first week in September. They are left to right, Front. Mother Loyola and Sister Ursula, Charlottetown; Sister Irene, Saint John; Mother Ignatius, Glace Bay; Sister John Baptist, Charlottetown; Sister Catherine Gerard, Halifax; Sister Marie Idieltrude, Cheticamp; Sister Mary Stanislaus, Charlottetown; Sister Elizabeth Maria, Cheticamp. Second Row: Sister DeLellis, Saint John; Sister Mary Angela, Charlottetown; Sister Anna Seton, Sister Francais de Paul, Sister Maria Paula and Sister Marion Estelle, Halifax; Sister Mary of the Sacred Heart, Sister St. Stanislaus, Chatham; Sister Margaret Patrice, Halifax; Sister Anne de Paredes, Sister Marguerite de Louvain, Moncton. Third Row: Rev. D. McCormack and Rev. A. I. MacAdam, Antigonish; Rev. M. J. MacKinnon, Glace Bay; Rev. J. R. MacDonald, Antigonish; Rev. A. J. MacIsaac, Inverness; Rev. Dr. J. E. Burns, Dartmouth.

agreement as to what these properties are. However, their relative importance is highly controversial. The competition between the producers of mortar materials is very keen, and it is to be expected that each manufacturer will emphasize the importance of the particular mortar properties to which his own material contributes. Frequently one property of mortar is obtained only at the expense of another. Some plasticizers, for instance, which increase the workability of the mortar also tend to reduce its strength.

Quoting from an article by L. A. Palmer of the Bureau of Standards, Washington, D.C., the ESSENTIAL PROPERTIES OF GOOD MORTAR are summed up as follows:

"(1) Workability (water retaining capacity being the controlling factor);
(2) Adhesiveness of bonding power, a high ratio of tensile bond strength to tensile mortar strength;
(3) Low volume changes subsequent to hardening;
(4) The maximum amount of strength obtainable without any material sacrifice of plasticity, bonding power and low volume changes after hardening;
(5) Extensibility, the property of undergoing a relatively high degree of stretching without rupture;
(6) Freedom from soluble matter that contributes to efflorescence staining, etc.;
(7) A fair degree of porosity."

Winter Construction

We quote the following from the National Building Code: "When there is likelihood of a temperature of 32°F or less, adequate equipment should be provided for heating all materials entering into masonry construction. No frozen materials, or materials containing ice shall be used. Masonry shall be protected against freezing until such time as the setting of the mortar has advanced far enough to prevent any displacement of the masonry on subsequent thawing." And with regard to *concrete* we quote: "Adequate equipment shall be provided for heating the concrete materials and protecting the concrete during freezing or near freezing weather. No frozen materials or materials containing ice shall be used. Concrete mixed and deposited when the temperature of the surrounding atmosphere is 40°F or lower, shall have a temperature of not less than 50°F, nor more than 100°F. Effective means shall be provided for maintaining the temperature of the concrete at not less than 50°F for at least 72 hours after placing. Whenever the atmospheric temperature is less than 50°F, a continuous record of atmospheric temperatures in the vicinity of the concrete shall be kept. No dependence shall be placed on salt or other chemicals for the prevention of freezing."

To obtain satisfactory results *brick should never be laid in freezing weather.* If the temperature is much below 32°F during the day, so that it is likely to freeze during the night, precautions should be taken to see that the walls, on which work was done during the last few hours previous to stopping work for the day, are well covered with tarpaulins or other suitable coverings. On commencing work each morning a careful examination should be made, and if any of the work is found to be frozen, it should be taken down and the brick relaid. All the materials including sand, lime, cement and brick should be kept in a temporary heated shed. These materials should not be in contact with the ground. The brick and mortar should only be taken up to the stage in such quantities as can be used within a reasonable time. These methods may be used in emergencies, but the laying of

(*Concluded on page* 76)

ONTARIO HOSPITAL ASSOCIATION
CONVENTION
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We would like to be with you... but—

It has always been a pleasure and pride to us to be represented at the Convention of the Ontario Hospital Association. Past years have seen the familiar Bassick Exhibit at the Convention as a token of goodwill in business.

This year however the need for increased production under conditions of extreme urgency and the unusual circumstances in the deliveries of raw materials have forced us to forego our keen desire to be present.

In these circumstances we feel we can best serve by concentrating solely on production in order to give the very best service to Canadian industry under today's conditions. For example below we show one of our latest lines—the new Bassick Diamond-Dart Caster shortly to be introduced. We send our warmest greetings to the Convention in its task of successfully furthering the work of the Association.

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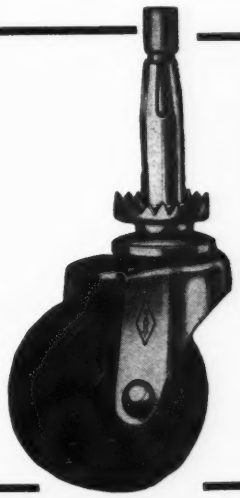

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Here and There

By The EDITOR

Misinforming the Public

Last month a writer in *Saturday Night,* the well known Canadian weekly, had a lengthy article on the Pfeiffer technique of diagnosing disease. It was unfortunate that the writer was more interested in boosting the Pfeiffer technique than he was in verifying the statements made in his article.

The writer infers that it is so far outside the field of orthodox scientific research that it has been dismissed as mere quackery. At the same time, he states that the few doctors who have made use of it have had 100 per cent success in diagnoses. The writer states that as far as he knows, there is not a single doctor and not a single hospital using the Pfeiffer technique of diagnosis.

The Pfeiffer technique is a method devised in Switzerland whereby solutions of water, blood and copper sulphate solution are allowed to crystallize. From the arrangement taken by the crystals forming on the glass plate diagnoses are made. The writer claims that "this is the method of diagnosis of the future. It can detect not only cancer, but tuberculosis, asthma, stomach ulcers, various mental afflictions and almost every disease under the sun, quite painlessly and quite infallibly, once the rather difficult technique has been acquired."

Had the writer checked with the medical literature in his local medical library, he would have found that in the Canadian Medical Association Journal in August of last year the leading article was by Dr. O. C. Gruner of Montreal, who reported on the experiments which he has been conducting for some time under a grant from the Archibald Cancer and Research Fund of McGill University. Unlike the article in *Saturday Night,* which simply makes statements without any scientific proof or references, Dr. Gruner's article is a very careful and scientific analysis of an extensive series of experiments on the diagnosis of cancer. Dr. Gruner did not claim 100 per cent accuracy in diagnosis. The readings were correct in 90.1% in cancer cases and in 91.1% of the non-cancer cases, but he did fail to obtain a positive result in 12 out of 122 undoubted cases of cancer. Pfeiffer himself reports correct diagnosis range from 70 to 83%. Despite a margin of error, Dr. Gruner places high value upon this test. With evidence of Canadian research available in our medical literature, it was unfortunate that the impression should have been given to the public that Canadian medicine is not going to follow up any promising field of investigation.

* * *

A Plan that Failed

When Dr. F. A. Washburn of Boston received the annual A.H.A. Award of Merit in Atlantic City in recognition of his long career of service to the hospital field, he acknowledged in his humorous reply that he suffered from the lack of an ability highly desirable in an administrator, namely, the ability to remember names.

For example at his Cape Cod summer home he had a fine juniper tree, but could never remember what to call it. One autumn he had an inspiration: January, February, March, April, May, June—*Juniper!* Next spring when he went back to Cape Cod and spied this tree he could not understand why the magic formula did not work, despite the fact that he conscientiously repeated Sunday, Monday, Tuesday—etc.

* * *

The Man Without a Home

One of the disadvantages of being at home in every state and province is that there are times when such a cosmopolitan individual hardly knows which is his home. The House of Delegates of the American Hospital Association draws together the leaders in hospital work from the whole continent; yet it looked for a while as if its very democratic nature would exclude that most essential of leaders, Dr. M. T. MacEachern. Facetiously he often gives his address as "Pullman Car, North America". However, as "Pullman Car" is not entitled to a representative, he has, for the last two years, proudly answered to the call for the delegate from Delaware! This year he was found to have changed his residence to Wyoming. The main thing is to have him there.

* * *

Indian Ambulance in London Has Proud Record

An Indian ambulance unit in London holds a most distinguished record—for it has answered more calls and (politely) attended more "incidents" than any other unit in its large district. During a particularly heavy raid they were bombed out of their station but carried on from a public telephone booth, which they made a headquarters for incoming calls. According to T. A. Rama, an Indian journalist in London, the unit prefers that its claim to fame shall be that they make the best curry found outside of India.

* * *

Southerner Makes Good in North

Graham L. Davis who is well known to many Canadians in the hospital field has been named president elect of the Michigan Hospital Association. Graham Davis had charge of the small hospital work of the Duke Endowment in the Carolinas for many years and was deeply interested in the small hospital problems of Canada. Because of the work of the Duke Endowment in building up what is generally considered to be the finest chain of small hospitals on this continent, he was appointed last year by the Kellogg Foundation to direct its rural hospital programme in Michigan. Already wonders have been accomplished in selected model areas by this soft-spoken yet dynamic enthusiast. A lawyer by training, Graham Davis served as a pilot in France during the last war.

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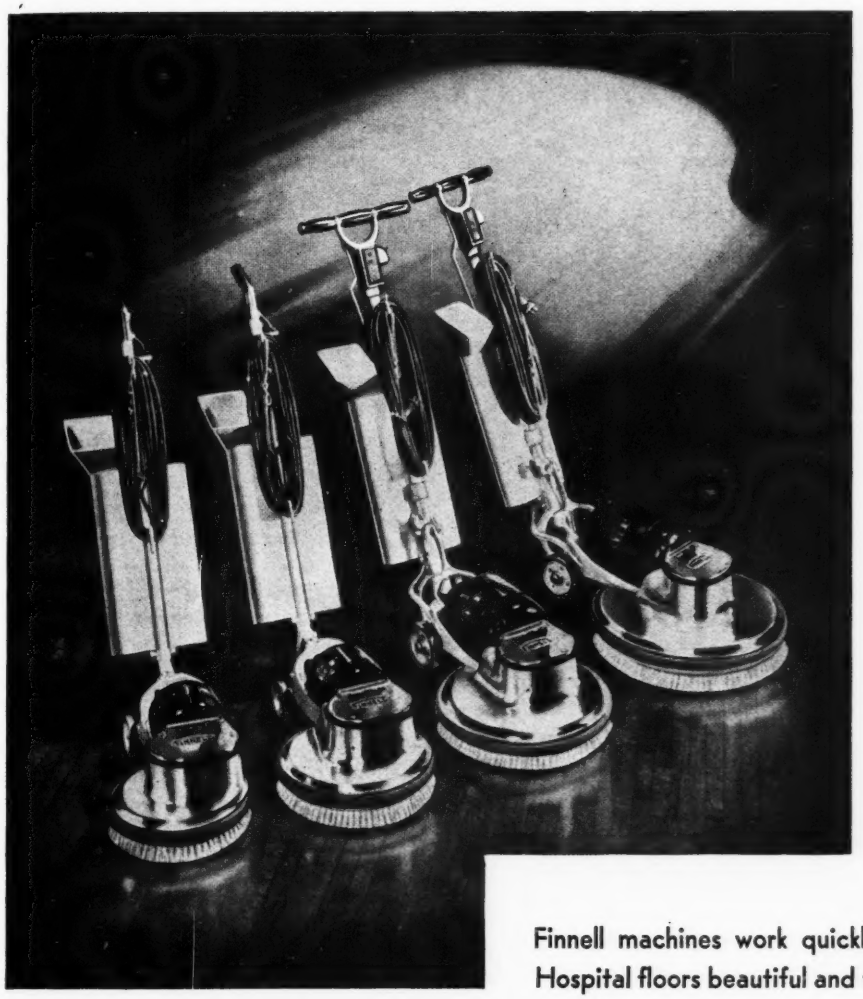

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How to Build A Convention Programme

Dr. MacEachern Addresses Association Officers

ESSENTIAL factors in the preparation of a convention programme were outlined by Dr. M. T. MacEachern at a luncheon of state, provincial and other hospital association presidents and secretaries during the American Hospital Association convention at Atlantic City. Among the points emphasized were the following:

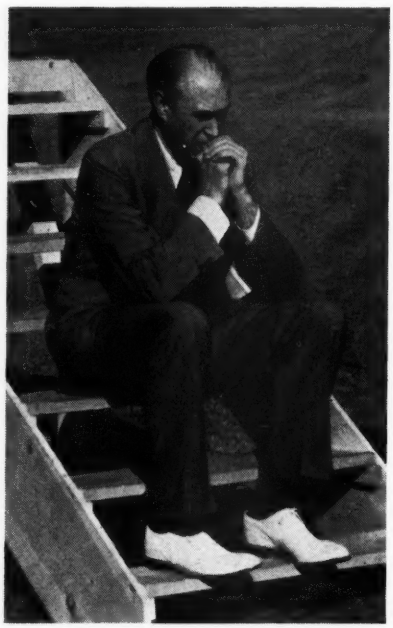
1. Select a committee that is alive and that will work well together;

2. Start a year ahead to plan the programme.

3. Review the programmes of the last five years to ascertain what subjects have been well covered and which have been neglected;

4. Analyze and set down vital topics of the day; consider also those subjects relating to needs or developments which should be discussed;

5. Work out a balanced programme; remember that all groups of hospital workers should be considered, (at the Tri-state meeting in Chicago next May fifty-one (!) separate groups or organizations will participate or hold sessions);



A candid shot of Dr. MacEachern wishing he were quintuplets so that he could be in Texas, Montreal, Boston, Vancouver and Chicago at the same time.

6. Do not overcrowd the sessions; ordinarily two or two and one-quarter hours is a sufficiently long period for one session;

7. Select speakers as carefully as one selects a subject.

8. Speakers should be urged to speak from notes rather than to read a paper; it is always received better by the audience;

9. The use of charts, lantern slides and motion pictures should be encouraged; the visual approach is to be commended;

10. Papers should not be long; if lengthy, highlights only should be read;

11. The value of discussion is dubious; unless well arranged, the discussion is apt to lead to considerable loss of time;

12. Round table and panel discussions are usually very popular, if properly led;

13. A quiz programme provides an interesting session;

14. Speakers should be given ample and early instructions with respect to date, title, location and time available.

American College of Hospital Administrators Holds Impressive Convocation

"Private philanthropy is far from dead and will continue to go a long way to finance our hospitals" was the optimistic message brought to administrators by Asa S. Bacon at the Annual Convocation of the American College of Hospital Administrators at Atlantic City on September 14th and 15th. Last year millions were given to charity and it is fair to anticipate that our voluntary hospitals will long remain in service.

Twenty-nine new members, thirty-four new associate members and one Fellow were added to the College roll at the Convocation ceremony. Two Canadians were included in this list, Sister Mary Loretto of St. Joseph's Hospital, London, and Pilot-Officer Gordon A. Friesen, formerly of the Belleville General Hospital. Mr. Bacon was made an Honorary Fellow in recognition of his forty years of administration at the Presbyterian Hospital, Chicago, and his many years of leadership in the American and other hospital associations.

Speaking on the subject "This Revolutionary Age", Sir Willmott Harsant Lewis, Washington correspondent of *The London Times,* gave an eloquent and learned address at the annual banquet. Sir Willmott emphasized that sacrifice, not a search for security, is the real social virtue to-day. He warned, too, that no country can be stronger than the spirit of its working masses. A session on social welfare, on national defence and on administration completed the programme next day. The alumni of all of the various institutes on administration held in various parts of the country under the aegis of the College during the past several years combined in one joint "institutes" dinner on one of the evenings.

Dr. Lucius R. Wilson, administrator of the Protestant Episcopal Hospital in Philadelphia, succeeds Dr. Arthur C. Bachmeyer of Chicago as President. President-elect is Joseph G. Norby, superintendent of the Columbia Hospital in Milwaukee. Mrs. Jewell W. Thrasher of Dothan, Alabama, was elected First Vice-President and Oliver S. Pratt of Salem, Mass., Second Vice-President.

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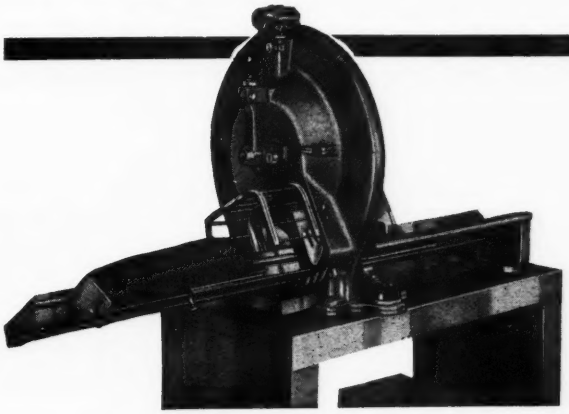

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More Medical Officers Needed

Word has been sent out that the Defence Services require approximately 210 doctors for service overseas and 140 doctors for service in Canada. For overseas services the doctors should be preferably under 40 and in Category A; for home service doctors will be accepted up to 55 years of age and may be in Categories A, B, or C. The Canadian Medical Association, through its provincial divisions, is co-operating by listing all doctors who desire to serve and who fill in the following form:

PRO FORMA

OFFER OF SERVICE

1. Name ..... (Surname) (Christian Names)
2. Address .....
3. Age .....
4. Qualification and Degrees .....
5. University and date of Graduation .....
6. Date of qualification in Dominion or a Province .....
7. Special Experience .....
8. Availability (taking into consideration civilian, University, or hospital needs)
9. Any other details necessary (*e.g.* physical condition, marital status, dependents)
10. Indicate service in order of preference:—
    Navy ☐ Army ☐ Air ☐
11. Any previous service with Armed Forces? ..... If so—
    Length of time .....
    Branch .....
    Rank .....

(*Signed*) .....

Date .....

To CANADIAN MEDICAL ASSOCIATION, (OR PROVINCIAL DIVISION)
184 COLLEGE STREET, TORONTO.

The Young Physician and the War

The Royal Canadian Medical Corps will need medical officers in increasing numbers. If the Canadian medical profession is to live up to the standard set in 1914-18 (and it will), 4,000 physicians will eventually (and they may be needed speedily) enter military service. Five hundred can be spared to the Royal Army Medical Corps, and are needed badly now. Arrangements have been completed for the expeditious transfer of all who apply.

Young physicians with practical experience are needed. There must be at least 2,500 physicians in Canada under the age of 35, and at least 4,000 under the age of 40. To every physically fit physician in Canada of military age the call comes more and more insistently. Some one must defend his home and family, and the hundreds of thousands of Canadian men who are undertaking and will undertake that sublime duty must have medical service, not alone that of the youth fresh from college, but that of the practitioner of somewhat more mature years and experience. No citizen deserves better medical attention than he who takes up arms in defence of his country, King and Empire. As for the young physician, the importance of his career and of his economic future pales into insignificance beside the needs of the critical situation to-day, and disappears completely if Hitler wins. Churchill has well said, "Without Victory there is no survival".

The young Canadian physician must give increasingly serious thought to the matter of military service. He must face these facts, viz.—

1. There is a crying need for medical officers in the Royal Army Medical Corps and in the Emergency Medical Service in the Motherland.

2. The Royal Canadian Army Medical Corps will need officers in increasing numbers.

3. Canada's quota of physicians for military service, based on the record of 1914-1918, would be 4,000.

4. The young physician has an additional responsibility in that the cost of his training is so largely borne by the state.

5. His whole professional career and the economic interests of himself and his family hang critically in the balance to-day. His contribution to the safeguarding of these things is very much needed. The survival of the British Empire is vital to them all.

Dorothy Thompson has said, "Before this epoch is over, every living human being will have chosen; every living human being will have lined up with Hitler or against him. When a boat sinks every passenger either stays on or gets off. If he can't decide, he has decided". Canada has decided to throw into the struggle every dollar, every man, every machine. Canadian medicine will decide (as it did in 1914-1918) to throw into the struggle at least 35 per cent of its personnel. The young Canadian physician must decide to throw his all on the altar of devotion to his Homeland, King and Empire, thereby insuring to himself, his children, and to generations of Canadians yet unborn that freedom and those liberties secured and preserved for him and for us by the "blood, toil, tears and sweat" of past generations of our ancestors.

—Lieutenant-Colonel W. J. Deadman, V.D., (C.A.R.) in the Bulletin of the Ontario Medical Association.

RESOLUTIONS
at the Canadian Hospital Council Meeting

Health Insurance

WHEREAS the Department of Pensions and National Health is now taking steps to formulate plans for a possible plan of health insurance which may be introduced at a future date;

AND WHEREAS the hospitals of Canada, particularly the voluntary non-profit hospitals, which have pioneered in this field of service and which constitute the great majority of our hospitals, are vitally concerned lest any change in the basis of providing medical care would affect their ability to continue their service to the sick;

BE IT RESOLVED that the Canadian Hospital Council, in convention assembled,

1. Assure the Government of Canada of its desire to co-operate in any sound plan for improving the quality and lessening the burden of the cost of medical care;
2. Express the hope that in the formation of any plan of health insurance, national or provincial, the integrity and continued utilization of the voluntary hospitals be assured;
3. Express its appreciation for the privilege given to the Council to have representation at the preliminary conference in Ottawa on June last;
4. Express the hope that if and when an advisory or other board representing interested bodies be set up, the Canadian Hospital Council be accorded the privilege of naming a representative.

Soldiers' Dependants

WHEREAS hospitals all over Canada are reporting an increasing number of soldiers' dependants who are unable or unwilling to pay for hospital service;

AND WHEREAS many municipalities decline to pay for such hospitalization on the ground of soldiers' dependants in receipt of assigned pay and allowances are not indigents;

AND WHEREAS this present situation results in a hardship both to soldiers' dependants who pay their bills and to hospitals who render service to dependants who cannot or do not meet their obligations;

AND WHEREAS helpful as it would be to have dependants enrolled in local hospital care plans, such is usually not possible, owing to the lack of a plan in most communities, the hesitation of plans to enrol dependants with their higher incidence of sickness without the breadwinner, and the frequent movement of dependants from one community to another;

BE IT RESOLVED:

1. That the Canadian Hospital Council strongly urge the setting up by the federal government of a plan of hospital care insurance to cover all soldiers' dependants resident in Canada, such to be financed by a small monthly deduction at the source from assigned pay and allowances; furthermore;
2. Should it be found necessary to bonus the present allowances to meet the rising cost of living, that a portion of such bonus increase could well be in the form of hospitalization benefits.

Supply of Nurses

WHEREAS there is at present a very serious shortage of qualified graduate nurses;

AND WHEREAS this shortage is becoming more acute and will be of serious concern both with respect to Defence nursing services, if the war be prolonged, and to civilian nursing needs during the war and rehabilitation periods;

BE IT RESOLVED that this Canadian Hospital Council,

1. Urge approved schools of nursing to enroll as large classes of probationers as local circumstances render feasible; and
2. In view of the increased cost to hospitals of temporarily enlarging their schools of nursing for war needs beyond their own local requirements, urge the Federal Government to work out a plan whereby approved schools of nursing can be assisted by an adequate subsidy, as is now done as an emergency measure in the United States, in order to undertake this additional training.

Miss Jean I. Gunn

WHEREAS the hospital and nursing world has, within the last few months, lost by death one of its most valuable and esteemed members in the person of Miss Jean I. Gunn, for over twenty-five years superintendent of nurses at the Toronto General Hospital, a woman of most outstanding ability and understanding, always ready and willing to give of her experience to those who had need, universally respected and beloved,

BE IT RESOLVED that we, the Canadian Hospital Council in conference in Montreal, wish to record our recognition of the great loss sustained by the hospital and nursing world in the death of Miss Gunn.

Gift of Mr. C. A. Edwards

WHEREAS Mr. C. A. Edwards, owner of the Canadian Hospital Publishing Company and publisher of THE CANADIAN HOSPITAL, has kindly offered to donate the publishing rights of this Journal to the Canadian Hospital Council without cost;

BE IT RESOLVED that the Canadian Hospital Council express to Mr. C. A. Edwards its deep appreciation of his generosity in presenting to the Canadian Hospital Council the publishing rights of THE CANADIAN HOSPITAL. It is recognized that, over the years, Mr. Edwards has made a notable contribution to hospital work in Canada by developing this journal which he has always placed so willingly at the disposal of the Council.

National Statistics

In view of the support given by the Dominion Bureau of Statistics to the Canadian Hospital Council in developing greater uniformity of statistical return across Canada;

BE IT RESOLVED that the Canadian Hospital Council urge full co-operation with the Dominion Bureau of Statistics in this important work.

FURTHERMORE it is urged that use be made of medical record librarians to clarify and make more valuable the scientific statistical data from year to year.

Co-operation with the Department of National Defence and the Department of Pensions and National Health

BE IT RESOLVED that the Canadian Hospital Council assure the Department of National Defence and the Department of Pensions and National Health of its wholehearted appreciation of the national health problems so far encountered and, furthermore, that it give assurance of its desire to co-operate in any future development of the activities of the Departments relating to hospital work.

Federal Participation

BE IT RESOLVED that the Canadian Hospital Council express appreciation of the participation at these meetings of the representatives of the Department of Pensions and National Health, of the Departmen of National Defence (Army, Navy and Air), and of the Dominion Bureau of Statistics.

Biennial Meeting

BE IT RESOLVED that this meeting recommend a change in calendar date of the biennial meeting from the month of September to the month of March.

Appreciation

BE IT RESOLVED that the Canadian Hospital Council express appreciation to all who participated in the discussions, thus making the meeting such a success, and to express appreciation to all whose services in various capacities were so cheerfully and efficiently given, this to include the Montreal Hospitals, the chairmen and members of the study committees, the management and staff of the Windsor Hotel and the newspapers of Montreal.

Canadian Medical Association

BE IT RESOLVED that the Canadian Hospital Council send a letter of appreciation to the Canadian Medical Association for its support and contribution of $300.00 towards the publication of the Council bulletins.

American Hospital Association and the American College of Hospital Administrators

BE IT RESOLVED that the Canadian Hospital Council send greetings through its secretary, a past-president of the American Hospital Association, to the American Hospital Association, the American College of

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Hospital Social Problems

(*Concluded from page 44*)

ship and experiment between social investigation, assistance and supervision and adaptation of hospitalization resources.

(6) Hospital Participation in Community Planning

Collaboration in out-patient service and social service is only one aspect of the necessity for more co-operative discussion and planning, both in service and finance, between the hospitals and the social agencies, for the former are being glimpsed more and more as centres within the community life rather than merely custodial treatment units. The whole question of hospital participation in community planning and in financing from voluntary funds, especially in a day of increasing taxation, is one that well points the way to more discussion between the social agencies and the hospitals.

(7) Reciprocal Residence Provisions

Because homeless or non-resident men have been absorbed to such large degree in active service or war production, there has been a dangerous assumption that the problem has solved itself. As a matter of fact, all elements are present for its greater aggravation. The transfer of labour, much for heavy semi-skilled temporary work, is playing "puck" with residence and settlement liability in hospitalization as well as social aid; while the increasing volume of service dischargees for inefficiency in army life, promises no particular holiday in the problem of the casual and maladjusted worker. The Canadian Welfare Council cannot abandon the responsibilities it assumed in 1938 in this field. It will attempt to continue its studies and efforts for more constructive statutory and community provisions for non-resident persons. It has just issued a comparative study "Residence and Settlement Legislation in Canada", and has in preparation a short description of Vancouver's experiment in individual case service to homeless men.*

We seriously recommend a closer affiliation between social welfare agencies and hospitals and would point out that not the least of the benefits to be obtained is that affecting the financial welfare of the hospital in the matter of furnishing hospitalization to problem cases.

* War Without End—Part I.

Manitoba Hospital Convention Programme

Fort Garry Hotel, Winnipeg, October 15th

9:00 a.m.	Registration
9:35 a.m.	Invocation Address of welcome—Mayor John Queen
9:45 a.m.	President's address Reports of Treasurer and Secretary Appointment of Resolutions Committee Appointment of Nominating Committee
10:30 a.m.	Special Committee on Increased Revenue to Hospitals—Mr. J. M. George, K.C., Chairman. Discussion led by Dr. H. Coppinger, Superintendent, Winnipeg General Hospital
12:30 p.m.	Luncheon—Fort Garry Hotel Address—Hon. J. O. McLenaghen, K.C., Minister of Health and Public Welfare.
2:00 p.m.	"Hospital Nursing Service in the Present Situation." Miss Jean Davidson, R.N., Superintendent of Nurses, Children's Hospital of Winnipeg.
2:30 p.m.	School of Nursing in the Small Hospital. Mr. W. R. Bell, Souris & Glenwood Memorial Hospital Discussion led by Miss G. A. Johnson, R.N., Superintendent, Neepawa General Hospital
3:00 p.m.	"Can a Dietitian in a Small Hospital Serve in a Dual Capacity?" Miss Margaret Coates, B.Sc.H.E., Brandon General Hospital
3:15 p.m.	Intermission
3:30 p.m.	Hospital Medical Records
3:45 p.m.	Hospital Pharmacy
4:00 p.m.	Developments of Group Hospital Service. Mr. P. W. Dawson, Manitoba Hospital Service Association
4:30 p.m.	Personality and Psychology in Hospital. Dr. Harvey Agnew, Secretary, Canadian Hospital Council
5:00 p.m.	Adjournment.
7:00 p.m.	Dinner—Fort Garry Hotel. Address by Dr. Harvey Agnew Report of Resolutions Committee. Report of Nominating Committee Unfinished Business Adjournment

Another State Medicine Plan for New Zealand

The government of New Zealand is still working on a plan for putting the medical care of the people under state control. The measure adopted last year did not prove tenable because it was so unacceptable to the medical profession that almost as a body the doctors refused to have anything to do with it. The new measure introduced into the House of Representatives last month will provide for national free medical care with the doctors receiving recompense from the social security fund.

The fee is fixed at the equivalent of $1.00 when the patient visits the doctor and at $1.25 when the doctor calls on the patient. For country practice practitioners may get mileage fees of twenty-five cents a mile if they travel more than 20 miles in making a visit.

The measure provides that these fees must be accepted as full payment, the doctor not being entitled to sue for further fees except by permission of the Ministry of Health. No fees were set for specialized service to patients, although this might come later. At the present time all doctors would receive the same fee. Patients who do not wish to obtain benefits of the Bill could pay their doctors privately, but the payments would be limited to the amounts stated in the Bill. This measure would seem to be as impossible from the medical viewpoint as its predecessor and is being opposed by the doctors.

Principles and Techniques of Hospital Purchasing

EDGAR C. HAYHOW

PART I

SOUND management must be based on a definite set of principles to which every departmental function must contribute its part. American hospitals purchase some 5,000 commodities at a cost of about $450,000,000 annually. It is thus evident that effective purchasing plays a major role in sound management.

Any performance as diversified as purchasing calls for unlimited association and co-operation with various groups within and without the hospital organization. There must be a complete uniformity of purpose to permit a smooth administrative function. Means to measure effectiveness are essential for proper control.

Principles are defined as rules of conduct; they imply function, organization, purpose, economy and personal relations. The functions of a purchasing department are to procure by purchase the proper quantities of what is wanted, for delivery at a certain time and place, at the lowest price consistent with the requisite quality. (Davis.) If one-half of hospital earnings are expended for commodity purchase, it is reasonable to assume that a definite plan of purchase procedure be prepared and strictly adhered to. Such a plan should include every phase of purchasing—from the original requisition through quotation inquiry, purchase, receipt, inspection, storage, issuance and control. Yet plans in themselves must be subservient to general organization policies. Because of the importance of purchasing, the purchase policy should emanate from the trustee group or the governing body. Such a statement may be reduced to a simple paragraph, e.g.: "The Committee shall approve in advance the purchase of all articles, furniture and supplies, except in the case of purchases upon emergencies by direction of the Superintendent of the Hospital, and excepting the ordinary daily supplies purchased by the purchasing agent, who shall report monthly to the Committee regarding such purchases, and excepting purchases for the special departments in charge of the Special Clinical Departments Committee." The authority of the Board committee may be limited to purchasing or combined with some other trustee responsibility. The personnel of the Committee should be composed of persons familiar with purchase philosophy and practice or specialists in fields similar to hospital organization. A member of the Medical Staff should be included in such a committee to represent the clinician's viewpoint and to act as liaison between the professional staff and the administration. Such representation would in no way usurp administrative prerogatives; it would tend to foster them. The administrator of the hospital should be an ex-officio member of the committee as it is assumed he should be cognizant of all the policies within his jurisdiction. As the executive, it should be his duty to review the techniques of the department and its value to the vendor, the hospital and the community in terms of sound administration.

There is need for a definite philosophy concerning purchasing. Members of the Hospital Board Committee should know the intimate hospital organization in its particular adaptation to purchasing. Often it is the executive who must interpret these data. Economy is essential—basic—but perhaps subservient to other factors. It is for the directorate and the executive to determine whether the purchasing agent be an executive or a clerk. If an executive, he should keep informed of market trends and advise on matters of long term contracts. An efficient department enjoys perfect synchronization in relation to time, price, quantity, delivery, inspection and payment.

Every institution, especially in smaller communities, will meet the problem of purchasing locally. Community participation in financial programmes creates in the minds of some persons a sense of reciprocity. Yet contributions with ulterior motives should be discouraged. Hospitals are charitable institutions; they function in the interest of the public good. Board members are the custodians of a public trust; it is their responsibility to see that funds are spent judiciously. Hospitals should concentrate their purchases locally as far as possible; they should not be called upon to pay additionally for the privilege.

Likewise, pressures should not be exercised in favour of designated vendors. The department must function with the aim of securing prices advantageous to the hospital, quantity, quality and economy each in its proper ratio. Board members are in a rare position to offer counsel to executives and purchasing agents. Their professional knowledge, experience, position and connections can affect real savings. The right kind of help is invaluable.

Large hospitals and small hospitals, by virtue of their size, accept centralized purchasing. The middle sized hospital is more likely to use the decentralized method of purchasing through department heads. In the event of decentralization, all purchases should be confirmed in writing by the superintendent or a person designated by him. There is no doubt that centralized authority is more efficient than decentralized and the designation of a single pur-

(*Continued on page* 68)

From Manual of Specifications for the Purchase of Hospital Supplies and Equipment, published by the American Hospital Association.

Principles of Hospital Purchasing

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chaser merits consideration. The mere acceptance of a centralized plan is not a guarantee of success. It is necessary to select a capable purchaser and establish a system of sound practice.

Centralization creates a focal point for all purchasing activities. The officer is usually designated as Purchasing Agent. In many institutions the purchasing function is combined with other responsibilities. In this office revolve the mechanics of the department and with the guidance of a pre-planned policy, the major assignment is to fit a functioning institution within the confines of a more or less restricted budget. Central purchasing is efficient and economical. It fosters standardization of commodities, equipment, policies and performance. Often several hospitals combine for group purchase activity and localize purchases in central control.

Sound purchasing necessitates more than accepting requisitions and relaying them to suppliers by means of telephonic communication. It is deeper than that. A knowledge of quality, quantity and service must all be weighed in terms of consumption; the life and price of an article must be consistent to the demands of it and no more. A purchaser should judge the value of an article, not from his own standards nearly as much as from the experience of those using it yet economy must always be considered.

Hospitals should have a clear policy as to how far the institution should be expected to co-operate in the interest of purchases for staff and personnel. Naturally, each hospital should offer to its immediate resident staff advantageous discounts for commodities coming within the immediate purview of hospital practice. The purchasing department is responsible for the pricing of such requisitions and should arrange with the paymaster for monthly employee salary deductions. Such interest in purchasing for staff and personnel is good personnel relations. It should be a privilege on the part of the hospital, not a duty. But there is definitely a limit to such practice.

The functions of the department have been previously stated. Effective dispatch is necessary in co-ordinating them. Adequate inventories and detailed records make this possible. All information concerning all purchases must flow through this office, including the responsibility for charging and checking invoices. However, to assure proper control, each invoice should be countersigned by other than the purchaser for receipt, price and extensions. This is not, and should not be, a function of the department. Adequate personnel, consistent with standard ratios, is necessary for effective performance. Hours of employment, conditions of work, salary, including perquisites, should be comparable to similar jobs in other like institutions and in conformity with salary schedules in the same institution.

A purchasing agent is called upon to possess possibly more than the average education and personal attributes. He should be well integrated in the hospital scheme. A rating scale to measure his effectiveness would include accuracy, education, honesty, impartiality, knowledge of medical nomenclature and hospital supplies, and above all, experience. Special knowledge of economics, accounting, finance and commercial law is desirable. Above all he or she must not be petty. The aim of every institution should be to employ a person with as many of these attributes as the job and budget permit.

One is apt to judge a buyer and his attendant abilities in the light of his personal relations with the individual. Those in charge, in consequence, at times attempt to concentrate purchasing with certain jobbers; others rarely order the same commodity twice from the same supplier. Both have the same motive differently applied. The first is bad; competition is stimulating. The second is worse; it lacks stability in performance.

Perhaps no one person in the institution, other than the superintendent (if he does the buying) is apt to come in contact with as many differing personalities. An antagonistic approach should be avoided quite as strictly as a display of a disinterested laissez-faire attitude. All department heads and personnel eventually cross the threshold. The tools which employees use in discharging their duties may be a means upon which to hang their faith in their jobs and in the institution which they serve. Paper and pencils may be as important to secretaries and bookkeepers as sutures to surgeons. It is the seemingly insignificant things which have a tendency to "brand" institutions.

Fairness of policy and courteous treatment are naturally expected from one charged with such an important public relations post. This is particularly emphasized in relation to sales people. It is so simple for the vendee to be arrogant, smug, talk loudly and be a poor listener. Much knowledge may be gleaned from well-informed sales representatives.

In order to save time of both the buyer and seller, regular days and hours are set aside for purchasing various types of supplies—drugs, surgical equipment, food, household supplies are typical examples. This

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A.H.A. Award of Merit to Dr. F. A. Washburn

The Award of Merit gold medal of the American Hospital Association was presented at the Atlantic City meeting to Dr. Frederic A. Washburn of Boston. This award, instituted three years ago, is made to that member of the Association who has made the greatest contribution to hospital progress and welfare, not only in his own institution, but to the field as a whole.

This year the Award went to Dr. Washburn, a past-president of the Association and one who holds the unique record of seeing three of his assistants receive that honour. Dr. Washburn was long the director of the Massachusetts General Hospital and more recently directed the reorganization of the hospital system in Boston. A distinguished soldier, he has also proved himself to be an unusually fine author.

Previous recipients have been Dr. Malcolm T. MacEachern and Dr. S. S. Goldwater.

Sterilization Technique

Weedon B. Underwood

THE sterilization of utensils and instruments by boiling in water is fast giving way to their sterilization by steam under pressure—i.e. in the autoclave.

Boiling requires at least 20 minutes exposure and except under unusual conditions results in the deposit of lime or scale which is not easily removed and in the case of hinged instruments may deposit in locks and hinges and do serious injury. Pressure steam sterilization on the other hand leaves no deposits and can attain adequate sterilization in 15 minutes exposure. The utensils can be wrapped in muslin covers and after sterilization stored dry for use, just the same as in the case of dressings. In order to conserve space utensils may be placed on edge in the sterilizer, the same as recommended for dressings in jars.

Pressure steam heats instruments to the moist steam sterilizing temperature of 250° F. in one minute and it has been shown that even the resistant pathogenic spores are destroyed in one minute by moist steam at this temperature. As a routine, instruments should be sterilized for 10 minutes but in an emergency this period can safely be reduced to 5 minutes but should not be less on account of the possibility of concealed crusts of dried matter in the joints and crevices. Even reduction to 3 minutes carries a greater factor of safety than any so called emergency processes used in boiling instruments.

For the sterilization of infected instruments, they may be placed in the special tray direct from the operating table without previous washing, jointed instruments opened, covered with water and one tablespoonful of trisodium phosphate added. They are then sterilized for 15 to 20 minutes and when removed will be sterile and essentially clean, except for some tiny shreds of tissue which may adhere to the joints. They may then be wiped while still wet to remove the shreds, and then sterilized in the usual way. This eliminates practically all the work of cleaning and danger of handling while still contaminated.

Solutions

The common belief that certain heat sensitive solutions such as procaine cannot be successfully sterilized in the pressure sterilizer is erroneous. The use of non-pressure steam on three successive days is tedious, expensive and unnecessary. The pressure steam sterilization must however be carefully done and based on the required exposure period, this period being calculated not from the size of the load but on the size of the individual flasks in the load.

Thus a 1000 cc. flask of saline or dextrose solution may be sterilized by 15 minutes exposure at a maximum controlled temperature of 254° F.

But a 1 or 2 oz. bottle of procaine will be properly sterilized under the same operating conditions in 8 minutes. It is evident that containers of different sizes should not be included in the same load.

The following table of exposure periods has been prepared from carefully controlled observations using Florence flasks filled to about three-quarters capacity.

Size of container	*Exposure period*
2000 cc. flasks	20 min.
1500 cc. and 1000 cc. flasks	15 min.
500 cc. flasks	12 min.
250 cc. and 125 cc. flasks	8 min.
50 cc. flasks	6 min.

2 oz. ordinary straight sided thick glass bottles commonly used for procaine — 8 minutes.

Rapid exhaust of steam from the sterilizer after sterilization causes ebullition, blown stoppers and undue loss of fluid, while simply allowing the sterilizer to cool down will prolong the period of exposure and in the case of heat sensitive liquids may cause injury to the solution. The best method of cooling down solutions requires some skill and care in regulating the exhaust and is as follows: Turn off all heat, close valve admitting steam to the chamber and open exhaust valve very slightly, just enough to permit the pressure to drop to zero in 7 to 10 minutes. This will reduce the amount of the liquid about 5% and it is therefore necessary that this amount of water be added to the solution before sterilization.

Rubber Goods

Period of Pressure must be limited to 15 to 20 minutes to prevent serious destruction of the rubber. Two rubber surfaces in contact prevent exposure to the steam. Gloves should be stuffed with at least a quarter of an inch of crinkled tough paper in the hand portion, and, if the fingers are not collapsed in wrapping, the steam will have sufficient entrance. When the wrists are folded back two or three layers of paper or a pad of gauze should be interposed between the two surfaces. Gloves should not be folded in wrapping. Glove should be loosely wrapped and glove packs placed in sterilizer on edge.

Tubing should be so arranged as to ensure circulation through the bore. This can be done by wrapping the tubing in a spiral around a cardboard gauze covered cylinder or a rolled up towel about 5 inches in diameter and placing in the sterilizer on end. Exposure should be about 15 minutes and never exceed 20 minutes.

—Hospital Abstract Service, Chicago.

Ontario Plan for Hospital Care "Out of Red" in Five Months

After only five months of operation the Plan for Hospital Care operated by the Ontario Hospital Association is "out of the red". "Most large scale plans", stated the Director, Norman H. Saunders, "take about eight months on the average to pass this milestone." This has been accomplished despite a most unusual series of handicaps. As the plan is a group plan with payment by payroll deduction only, the deductions for War Savings Certificates, the increased National Defence Tax and now the Unemployment Insurance deductions, added to from five to eight other deductions, have made the task of the enrolment staff an unusually difficult one.

The plan now has enrolled some 16,000 members and dependants and is gradually extending its operations to additional centres throughout the province.

There is no such thing as a "bedside manner." There are only bedside good manners.

—Frank Reggall, M.D.

The Choice of a Hospital Director

Physican, Nurse or Layman

AMONG the factors which govern the choice of a physician, nurse, layman, or laywoman to be superintendent of a hospital are the medical type, the form of ownership, and the size of the hospital. About 20 per cent of physician superintendents other than those at the head of proprietary hospitals are found in hospitals of 25 beds or less, yet nearly two-thirds of the hospitals of 200 or more beds have physicians as superintendents. The nurse superintendent is found chiefly in non-governmental charitable hospitals of less than 100 beds; she appears also in about 20 per cent of the non-proprietary hospitals of 11 to 25 beds, while about 13 per cent of nurse superintendents are at the head of hospitals of over 100 beds. About 70 per cent of the laywomen superintendents are in small voluntary charitable and proprietary hospitals, only about 6 per cent being in hospitals of over 100 beds. Laymen superintendents are found chiefly in hospitals operated by independent charitable corporations, in state and county hospitals, and in the hospital departments of custodial institutions, regardless of the size of the hospital.

Advantages in the Career of Superintendent

The superintendent of a hospital carries heavy responsibilities, but if he is socially-minded he finds a satisfaction in administering an institution of service and in carving out new paths for its usefulness. For him the advantage of being of use to the community far outweighs the strain of responsibility.

Another advantage of the work is variety which makes for interest. Most superintendents will say that no two days are the same, but that each day brings new problems and new contacts. To meet all of these new situations successfully, the live administrator must read, attend conventions, and visit other institutions. Thus he never has a chance to stagnate.

Again, the head of a hospital commands respect in the community, and his opinion is accepted as authoritative in his own and related fields. Through co-operation with civic and charitable organizations, he has the opportunity to make his personality felt and to put into effect plans and ideas of his own for the public good.

Another advantage is that the hospital field is a growing one, in which there is plenty of room for the successful man or woman to advance. It is a field, likewise, in which age is an asset, because experience is a large factor in securing an important position.

The following testimony of a woman superintendent sums up some of the advantages:

"The position appeals to me because a busy hospital keeps one alert mentally. One needs some knowledge of all professions, crafts, and trades. One is in touch with newer methods of nursing and medicine. When the private duty nurse must slow down and cut her salary in life, the superintendent is increasing her salary."

Disadvantages

Hospital administration has its disadvantages, but they vary in degree according to the size of the hospital, the locality, the make-up of the board, and various other factors. This statement should be borne in mind when balancing the disadvantages against the advantages.

Perhaps the most serious disadvantage is the strain of responsibility which every hospital head carries. Because the hospital deals with human life, and because so many unforeseen things can happen, the superintendent even when off duty is never quite free from a feeling of responsibility. Superintendents say quite frankly that their work is never completely off their minds. Such a condition makes for strain which only a strong man or woman can bear. In addition to the responsibility, the hours are often long.

Considering the responsibility of the work, the salaries are low in comparison. It is an advantage to receive maintenance, but this is not always included, hence, when a superintendent has a family to support, he frequently finds the same difficulty in making both ends meet that the man does who occupies a position carrying much less responsibility.

Conditions of employment are unstable, due partly to moves made by the superintendents themselves to better their financial condition. Other reasons assigned for the heavy turnover are inadequate preparation, political influence which affects the tenure of office in state and municipal institutions, the interference of board members in the administration of the hospital, and disagreements between the superintendent and members of the medical staff. Because of these conditions few superintendents feel that they can safely establish a home in any one place with the certainty of remaining there permanently. This is a drawback especially to the man with a family.

These disadvantages are serious, but it must be remembered that they are not all present in all hospitals, and that a good deal depends on the individual himself. After a man has gained experience and made a reputation, he is in line for promotion to one of the more important positions which pays a better salary and offers a larger sphere of usefulness. In such a position the superintendent is likely to have the help of an assistant superintendent, hence there is a lessening of the load of responsibility. Under these conditions, the disadvantages which are so many and so serious in some hospitals are minimized.

Opportunities

Hospital management is unique among occupations in that the de-

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From "Hospital Management as a Career", published by The Institute for Research, Chicago.

Construction

Construction of the new $85,000 wing to Grace Hospital, Windsor, Ontario, is going ahead on schedule and it is expected to be opened late in December.

* * *

Excavation work for the construction of the new maternity wing at the Penticton Hospital, B. C., has been completed. The new 2-storey wing will have accommodation for 15 beds, and will be known as the "J. H. Munson Wing".

* * *

Financial arrangements for the construction of a new wing at the Nanaimo General Hospital, B. C., have been completed. Plans are now in the hands of the architect, T. B. Marravy, for the 4-storey 42-bed addition. Estimated cost is $65,000.

* * *

The possibility of raising funds for building and furnishing a 15-bed hospital at Brooks, Alta., are being investigated by the provisional board of the Brooks municipal hospital district.

* * *

The Grey Nuns of Ottawa have decided to build a 25-bed hospital at Spirit River, Alberta. The Sisters took over the Spirit River Community hospital about six months ago and have now decided that it is too small to meet the needs of the district.

Cornerstone of Nurses' Residence Laid

The cornerstone of the new nurses' residence of Grace Hospital, Winnipeg, was recently laid by Hon. R. F. McWilliams, lieutenant-governor of Manitoba. The new building will accommodate over 100 nurses when it is completed, besides supplying accommodation for classrooms, dining-room and recreation rooms.

Principles of Purchasing

(*Concluded from page* 68)

permits certain days to be set aside for necessary office detail. The practice is recommended. However, there are arguments for and against this practice. Hospitals in the same community should join together in determining these schedules, otherwise it may be difficult and disconcerting for a salesman to visit a number of hospitals in a given area if each insists on different appointment days. The largest institution is bound to regulate the practice of the smaller.

The responsibility of purchasing assumes a moral trust. Principles of ethical standards are not new to hospital organization. Codes of ethics have found their inception within the limits of professional practice. Hospital purchasing is no less detached. One need not dwell on the result of the occasional instance which may have been detected as running counter to law. Opportunity may be available, while not openly flagrant, to come within the pales of unethical practice. Such practice discolours public relations; it handcuffs the offenders. Persons of inexperience are easy prey; a too generous policy under the guise of good fellowship creates entangling alliances. Experience soon dictates the policy as sound for limiting associations to the area of office practice and routine and commodities to the purchase order—dollar paid for dollar received; otherwise one sells himself out for a mess of pottage.

Every buyer should be familiar with the legal term "Caveat Emptor" —Let the buyer beware. Integrity strengthens confidence over and above a price basis. The sending of unordered material to a hospital so as to be able to make a "deal" is unethical. This practice is unscrupulous and should not be countenanced.

The Choice of a Hospital Director

(*Concluded from page* 72)

mand for trained workers is great, and yet facilities for training persons in any number are lacking. However, because of the rapid growth of hospitals and the lack of systematic training, the field of hospital management is full of opportunities for the right people. Persons trained in institutional management, scientific technique, minimum standards for hospital service, community welfare and public health activities are especially needed.

The opportunities for laymen and laywomen are increasing because of the fact that the prejudice against the acceptance by medical men of positions outside of hospitals is breaking down. Thus many physicians who would formerly have sought positions in hospital administration are accepting employment in public health work, teaching, research, clinical work and industrial medicine.

Qualifications

Because of the highly complex nature of hospital work, the head executive should be a person of superior intelligence, skill, and training. One of the first requisites is the ability to get along with people. Unless a man has tact, sympathy and self-control, he should never attempt to enter the hospital field. The successful superintendent must work in harmony with the board, keep his peace with the medical staff, deal wisely with the nursing force, listen sympathetically to the complaints of patients and their relatives, and be thoughtful of the body of employees who perform the routine work of the building. His spirit in handling these relationships permeates every department of the hospital and sets the standard. In addition to handling people tactfully, he must also be a good judge of human nature, in order to select the best qualified individuals when hiring them for the different departments of the hospital.

On the executive side, he must be able to plan and direct the work of others, in order to keep the machinery of the entire institution running smoothly. To assist him in purchasing wisely, he needs good business sense and sound judgment.

A successful superintendent must be sincerely interested in his work and genuinely sympathetic toward the ultimate object of the hospital —the welfare of the sick. He also needs vision to develop the work of the hospital around this objective and to widen the hospital's sphere of usefulness in the community.

A final qualification is the possession of good health, because a man or woman must be in fine physical condition to bear the heavy responsibility of the work and the many demands upon time and strength. This is an important consideration and should be borne in mind by those thinking of taking up hospital work. The hospital field is not the best place for those who are weak physically, even if they are brilliant mentally.

Rapport du Président

(*Continued from page* 27)

ne progresse qu'en rapport avec le nombre et la qualité de ses articles. Nous profitons de l'opportunité qui nous est offerte pour solliciter de vous l'envoi d'articles nombreux et variés, de nouvelles touchant les hôpitaux, et de photographies d'intérêt général.

Nous rendons hommage à l'éditeur du Journal, monsieur Edwards, qui, en plus du travail énorme que lui demande la publication mensuelle du Journal, rend de nombreux services à votre Conseil.

Rapports des différents comités d'étude

Les rapports des différents comités d'étude qui seront lus à cette assemblée, représentent un travail considérable de la part de quelques membres de votre Conseil; nous les en remercions!

Nous tenons à rappeler à cette assemblée que les membres présents ont le privilège de critiquer, amender ou accepter les rapports tels que présentés; après leur acceptation, ces rapports seront publiés et distribués aux hôpitaux du Canada. Les informations contenues dans ces brochures sont inestimables, et nous espérons que les hôpitaux sauront en retirer un bénéfice.

Des recherches de grande valeur se font actuellement dans le service de physiologie de l'Université de Toronto, sous la direction du docteur C.-H. Best, sur le prélèvement et la conservation de sang humain pour la préparation des sérums.

Le Laboratoire Connaught fait la préparation d'un sérum en poudre; ce sérum a l'avantage de pouvoir être transporté et utilisé dans n'importe quel endroit; seule l'addition d'eau distillée est nécessaire. L'efficacité de ce sérum ayant été reconnue par les autorités compétentes, le Gouvernement Fédéral a voté la somme de $140 000 pour le coût de l'instrumentation nécessaire à sa préparation. L'Association de la Croix Rouge contribue pour une somme de $25 000 à l'aménagement des centres de prélèvement et à l'organisation du service des donneurs de sang. L'Association s'engage à faire le recrutement des donneurs, le prélèvement et le transport du sang au Laboratoire Connaught.

Le Gouvernement Fédéral, après s'être assuré d'une certaine quantité de sérum pour l'usage éventuel de l'armée au Canada et outremer, a pris l'initiative d'en expédier une certaine quantité en Angleterre pour la population civile.

Votre Conseil croit que les hôpitaux devraient prendre avantage de ces découvertes pour participer à l'accumulation d'une réserve de sang suffisante, advenant un raid aérien ou une conflagration au pays. Les hôpitaux civils pourraient, quand la chose serait jugée nécessaire, se procurer le sérum. Dans le cas où les patients recevant une transfusion seraient en mesure de payer, les frais ordinaires d'une transfusion leur seraient faits, et l'argent serait transporté à l'Association de la Croix Rouge. Cet arrangement serait porté à l'attention du public qui serait peut-être tenté de juger trop sévèrement les hôpitaux, relativement à la vente de sang humain donné gratuitement.

Seasonal Factors in Construction

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brick in freezing weather is not to be recommended if it can be avoided, unless the whole building is fully covered in with a temporary, weather-tight structure, which should be adequately heated with runs of steam pipes carried around the walls. All building materials should be kept inside this temporary structure.

Leaks in Masonry

The following has been taken from the March, 1939, issue of "Hospitals":

"Recently the United States Bureau of Standards completed tests on the water permeability of masonry walls both by simple absorption and under conditions simulating those occurring in a hard, driving rain. Five kinds of workmanship (filling of joints), three kinds of brick, six kinds of structural clay tile, two kinds of hollow concrete units, and six different mortars were used in construction of the test walls.

"It was found that the performance of each wall depended more upon the quality of workmanship than upon any other factor. Well-filled interior joints were usually tight, whereas poorly filled joints usually leaked. The use of mortars of medium or high water retentivity, the wetting of absorptive brick before use, and the application of the pargeting of mortar on the back of the facing withe all helped to make the walls more resistant. . . .

"On the average, if joints were not well-filled, walls with a brick facing and a backing of hollow masonry units were slightly less permeable than brick walls of equal thickness. With well-filled joints, the hollow units were somewhat superior to otherwise similar all brick walls in the capillary absorption tests, but inferior to the driving rain tests. . . .

"Colourless water-proofing did not stop leakage through openings in the joints, but improved the performance of walls of absorptive brick when the openings in the joints had been sealed. . . . "

Maritime Conference, C.H.A. Approves Clinical Procedures for Graduate Nurses

Among the resolutions passed by the Maritime Conference of the Catholic Hospital Association at their annual meeting held in Halifax in September was a resolution approving the action taken by the Joint Committee of the Canadian Hospital Council and the Canadian Nurses Association regarding the assignment of certain clinical procedures to selected graduate nurses. It was decided after a very keen discussion on state medicine, that the people must be educated to the advantages of voluntary agencies, and that the study of plans for a more complete health service through voluntary groups systems should be instituted immediately.

Gerhard Hartman to New Appointment

Gerhard Hartman has been appointed as administrator of Newton Hospital, Newton Lower Falls, Massachusetts, succeeding Miss Bertha W. Allen, on January 1, 1942. Mr. Hartman is Executive Secretary of the American College of Hospital Administrators, and Associate Director of the graduate course in Hospital Administration.

Book Reviews

SOCIOLOGY AND SOCIAL PROBLEMS IN NURSING SERVICE. By Gladys Sellew, Ph.D., B.S., R.N. Instructor in the School of Nursing, and Assistant Professor in the Department of Sociology, Catholic University of America, Washington, D. C. 344 pp. Price, cloth $3.25. W. B. Saunders Company, Philadelphia and London. McAinsh & Co. Limited, Toronto. 1941.

It has long been acknowledged that a nurse should be able to understand and interpret the patient's mental condition and reactions as well as his physical ailments and it is becoming increasingly clear that a knowledge of and an understanding of the patient's background and place in society is also necessary for the best nursing care. Dr. Sellew, a graduate nurse and a trained sociologist, with a wealth of experience at Il Poverello House, has written an excellent text based on the outline for the courses in Sociology and in Social Problems in Nursing Service published in the Curriculum Guide for Schools of Nursing published by the National (U.S.) League of Nursing Education.

C. H. C. Resolutions

(*Concluded from page* 62)

Hospital Administrators, and allied bodies now assembled in convention at Atlantic City and to reemphasize the spirit of loyal co-operation now so evident.

A.R.P. and Similar Activities

BE IT RESOLVED that this meeting go on record as endorsing the principle of preparedness for war emergencies, regardless of geographic location of any institution, and urge our hospital boards to give the matter the most serious and early consideration.

Rev. Father Moulinier

BE IT RESOLVED that the Canadian Hospital Council record its deep regret at the passing of Rev. Father Moulinier, Founder of the Catholic Hospital Association of the United States and Canada. Father Moulinier has done more to advance the progress of hospital care on this continent than can ever be realized. By his enthusiastic and wholehearted support of the standardization programme of the American College of Surgeons in its pioneer stages, he contributed greatly to its early general adoption by our hospitals. His work lives on in the labours of those who were inspired by his great leadership.

Dr. F. W. Routley

BE IT RESOLVED that greetings and appreciation for past services from this meeting go to Dr. F. W. Routley, Charter President of the Canadian Hospital Council, with our expression of gratification at his satisfactory convalescence.

The Canadian Hospital

BE IT RESOLVED that this meeting express earnest appreciation to the editor, to the publisher, to the advertisers and to the staff of The Canadian Hospital, with emphasis on the tremendous amount of efficient service given by Dr. Harvey Agnew. Furthermore the Council desires to emphasize the importance of hospital superintendents mentioning advertisers in THE CANADIAN HOSPITAL when ordering goods.

Rapport du Secretaire

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création d'une association dans laquelle serait groupées les trois Amériques. Un an plus tard, une convention était tenue à Porto-Rico; le succès a été sans précédent; des représentants des trois Amériques étaient présents en grand nombre. Le résultat ne s'est pas fait attendre, puisque nombre d'étudiants de l'Amérique du Sud et de l'Amérique Centrale fréquentent maintenant les universités de Chicago et des autres centres éducationnels.

Il est à espérer que l'Association internationale renaîtra un jour; à cet effet, une convention des administrateurs des hôpitaux des Etats-Unis, du Mexique, du Canada, de l'Angleterre et de l'Amérique du Sud, aura lieu à Atlantic City, sous peu. Le but de cette conférence est de créer une association anglo-américaine.

La présente assemblée tenue à Montréal,—le grand centre hospitalier du Québec,—sera quelque peu différente des assemblées tenues jusqu'à maintenant par votre Conseil, en ce sens qu'à l'exception de l'adresse du président et de certains rapports, le programme, dans son entier, sera sous forme de débats. Les principaux numéros apparaissant à notre agenda fourniront, nous l'espérons, suffisamment de matières à discussion pour permettre à tous de participer aux débats.

Les sujets apparaissant au programme sont variés; nous mentionnons ici les principaux:

a) De quelle façon la guerre affecte-t-elle les activités hospitalières?
b) Les contrats gouvernementaux avec les hôpitaux sont-ils ou non favorables à ces derniers?
c) Que penser de la construction par le Gouvernement Fédéral d'hôpitaux militaires?

Certains problèmes propres aux infirmières seront discutés par les délégués des différentes associations, entre autres, les résultats possibles de l'administration par des infirmières diplômées, des anesthésiques, des injections intraveineuses, etc. Les questions ayant trait aux lois provinciales et municipales régissant les hôpitaux, seront aussi débattues; les principales seront les suivantes:

a) Octrois provinciaux aux hôpitaux pour le soin des malades indigents;
b) Loi des accidents du travail;
c) Comptabilité des hôpitaux;
d) Construction;
e) Nomenclature;
f) Associations hospitalières,

et aussi un nombre considérable de questions diverses intéressant les hôpitaux.

Etant donné le retard apporté à la compilation des rapports préparés par les différents comités, les imprimeurs ont été dans l'impossibilité de nous les remettre avant l'assemblée, pour distribution. Ce contretemps nous oblige à demander aux délégués de confier aux nouveaux directeurs l'étude des rapports et de voir à leur distribution, après que leur acceptation aura été décidée.

La question de la distribution des frais de déplacement des délégués (pool) est de nouveau portée à votre attention; nous présumons que les arrangements antérieurement convenus seront de nouveau approuvés pour le prochain congrès qui aura lieu dans deux ans.

Le Conseil se doit de reconnaître les services précieux que lui ont rendus les membres du comité exécutif, et l'intérêt constant dont ils ont fait preuve au cours des deux dernières années; il les en remercie!

Notre président s'est montré très actif pendant son terme d'office, comme son discours présidentiel en fait foi; il a assisté aux quatre assemblées des Provinces de l'Ouest et à la conférence tenue à Chicago au cours de l'hiver, de même qu'à l'assemblée conjointe qui a eu lieu à Pictou.

Les remerciements du Conseil s'adressent également aux présidents des divers comités d'étude, de même qu'aux membres de ces comités, pour le zèle qu'ils ont déployé et pour le travail qu'ils ont dû s'imposer dans la préparation de leurs rapports.

—Harvey Agnew, M.D.

Miss Elliott Resigns at Port Hope

Miss E. Elliott, superintendent of the Port Hope Hospital, Ontario, since 1913, has resigned. Miss M. Gibb will succeed her.

COMING CONVENTIONS

October 15th—Manitoba Hospital Association, Fort Garry Hotel, Winnipeg.

October 16-17—Saskatchewan Hospital Association, Moose Jaw.

October 20-21—British Columbia Hospitals Association, Victoria.

October 20-31—The New York Institute for Hospital Administrators, Cornell University Medical College, New York City

October 29-Nov. ?—Refresher Course, Hospital Administration, McGill School for Graduate Nurses, Montreal.

November 3-7—American College of Surgeons, Copley-Plaza, Boston

November 10-22—Institute in Administration, School of Nursing, University of Toronto.

Defence Preparations A.H.A. Meeting

(*Concluded from page* 48)

A large number of American and Canadian officers attended a luncheon for the presidents and secretaries of state and provincial associations, the feature of which was an address by Dr. M. T. MacEachern on "Building a Convention Programme".

Medical record librarians, pharmacists, nurses, dietitians, purchasing agents, social service workers, auxiliary volunteers, trustees and those interested in small hospitals and in internships, all had their special sessions where many stimulating addresses were given.

At the President's Session, Dr. Benjamin W. Black of Oakland, Cal., gave his presidential address and Dr. F. A. Washburn of Boston received the Association's Award of Merit (described elsewhere). On this occasion the last of the bonds recently redeemed by the Association were publicly burned by Asa S. Bacon, the Treasurer, Dr. A. C. Bachmeyer, 1926 President, and Paul Fessler, 1932 President, the years when the First Mortgage and General Bonds were issued.

Dr. Basil C. MacLean, formerly of Montreal and New Orleans and now of Rochester, New York, took over the Presidency at the Annual Banquet. He follows a good man, but Dr. MacLean has excellent qualifications, is energetic, forceful and gives every promise of being a strong and popular leader. At this banquet the address was given by the Hon. F. H. Van Orman of Evansville, Ind., and the address at the dedication of the flags by Dr. Agnew. The new President-Elect, James A. Hamilton of New Haven, Conn., was introduced at this session.

It Almost Talks

The "Clucking Hen" is the name given to a device being used at the Leeds General Infirmary, England, to keep track of its supply of radium in an air raid. The radium is kept underground in a steel shaft and the "clucker" is a detector which "cackles" loudly at the distance of at least a yard from a mislaid radium needle. At this hospital several other devices are used to prevent any possibility of mishap to the x-ray operator, patients or plates. In the developing room, too, drawers close automatically and there are elaborate lighting and timing improvements.

—*The Hospital Magazine, Australia.*

Royal Victoria Hospital Receives Legacies

The Royal Victoria Hospital, Montreal, has received two legacies of $10,000 from the late Mrs. Jane Hastings, which are to help endow a public ward bed in memory of her brothers.

Price Trends

(On basis 1926 = 100)

	Yearly Average 1940	July 1940	June 1941	July 1941
Building and Construction Materials	95.6	96.0	108.4	109.0
Consumers' Goods (Wholesale)	83.4	83.4	90.6	92.0
(On basis 1932-1939 = 100)				
Cost of Living	105.6	105.6	110.5	111.9

Index of Advertisers

OCTOBER, 1941

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